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2013

Open to Public
Inspection

Form 990

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

- Do not enter Social Security numbers on this form as it may be made public. By law, the IRS generally cannot redact the information on the form
- Information about Form 990 and its instructions is at www.irs.gov/form990

A For the 2013 calendar year, or tax year beginning 10-01-2013, 2013, and ending 09-30-2014

B Check if applicable	C Name of organization BAPTIST MEDICAL CENTER OF NASSAU INC		D Employer identification number 59-3234721
<input type="checkbox"/> Address change	Doing Business As BMC NASSAU		
<input type="checkbox"/> Name change			
<input type="checkbox"/> Initial return	Number and street (or P O box if mail is not delivered to street address) 3563 Philips Hwy Bldg F Ste 608 Attn Mike Lee		Room/suite
<input type="checkbox"/> Terminated			
<input type="checkbox"/> Amended return	City or town, state or province, country, and ZIP or foreign postal code Jacksonville, FL 32207		
<input type="checkbox"/> Application pending			G Gross receipts \$ 67,498,288

F Name and address of principal officer
A HUGH GREENE
841 Prudential Dr Aetna Bld 1601
Jacksonville, FL 32207

H(a) Is this a group return for
subordinates? Yes No

H(b) Are all subordinates
included? Yes No
If "No," attach a list (see instructions)

H(c) Group exemption number ►

I Tax-exempt status 501(c)(3) 501(c) () (insert no) 4947(a)(1) or 527

J Website: ► WWW.BAPTISTJAX.COM

K Form of organization Corporation Trust Association Other ►

L Year of formation 1994

M State of legal domicile FL

Part I Summary

1 Briefly describe the organization's mission or most significant activities
CONTINUE THE HEALING MINISTRY OF CHRIST BY PROVIDING ACCESSIBLE, QUALITY HEALTHCARE SERVICES AT A
REASONABLE COST IN AN ATMOSPHERE THAT FOSTERS RESPECT AND COMPASSION

2 Check this box ► if the organization discontinued its operations or disposed of more than 25% of its net assets

3 Number of voting members of the governing body (Part VI, line 1a)	3	13
4 Number of independent voting members of the governing body (Part VI, line 1b)	4	9
5 Total number of individuals employed in calendar year 2013 (Part V, line 2a)	5	478
6 Total number of volunteers (estimate if necessary)	6	183
7a Total unrelated business revenue from Part VIII, column (C), line 12	7a	12,479
b Net unrelated business taxable income from Form 990-T, line 34	7b	0

	Prior Year	Current Year
8 Contributions and grants (Part VIII, line 1h)	0	94,464

9 Program service revenue (Part VIII, line 2g) 61,425,294 65,939,119

10 Investment income (Part VIII, column (A), lines 3, 4, and 7d) 809,832 802,355

11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) 2,259,998 662,350

12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12) 64,495,124 67,498,288

13 Grants and similar amounts paid (Part IX, column (A), lines 1-3) 33,295 46,125

14 Benefits paid to or for members (Part IX, column (A), line 4) 0 0

15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10) 24,284,829 24,145,806

16a Professional fundraising fees (Part IX, column (A), line 11e) 0 0

b Total fundraising expenses (Part IX, column (D), line 25) 0

17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e) 24,160,745 26,250,083

18 Total expenses Add lines 13-17 (must equal Part IX, column (A), line 25) 48,478,869 50,442,014

19 Revenue less expenses Subtract line 18 from line 12 16,016,255 17,056,274

	Beginning of Current Year	End of Year
20 Total assets (Part X, line 16)	97,608,635	110,049,071
21 Total liabilities (Part X, line 26)	10,273,516	10,649,621
22 Net assets or fund balances Subtract line 21 from line 20	87,335,119	99,399,450

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge

Sign Here	Signature of officer	2015-07-20
	SCOTT WOOTEN SVP & CFO	Date

Type or print name and title

Paid Preparer Use Only	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	Firm's name ►			Firm's EIN ►	
	Firm's address ►			Phone no	

May the IRS discuss this return with the preparer shown above? (see instructions) Yes No

Part III Statement of Program Service AccomplishmentsCheck if Schedule O contains a response or note to any line in this Part III **1 Briefly describe the organization's mission**

CONTINUE THE HEALING MINISTRY OF CHRIST BY PROVIDING ACCESSIBLE, QUALITY HEALTHCARE SERVICES AT A REASONABLE COST IN AN ATMOSPHERE THAT FOSTERS RESPECT AND COMPASSION

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? Yes No

If "Yes," describe these new services on Schedule O

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? Yes No

If "Yes," describe these changes on Schedule O

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported**4a** (Code) (Expenses \$ 47,911,361 including grants of \$ 46,125) (Revenue \$ 66,264,533)

BAPTIST MEDICAL CENTER OF NASSAU, INC (BMCN) IS A HIGHLY ADVANCED, EXTREMELY WELL-EQUIPPED COMMUNITY HOSPITAL ON AMELIA ISLAND THAT PROVIDES A FULL SPECTRUM OF INPATIENT AND OUTPATIENT SERVICES AND 24-HOUR EMERGENCY CARE TO COASTAL COMMUNITIES IN NORTHEAST FLORIDA AND SOUTHEAST GEORGIA. BMCN IS AN ACCREDITED CHEST PAIN CENTER, HAS EARNED MAGNET RECOGNITION FOR EXCELLENCE IN PATIENT CARE, AND OFFERS MANY ADVANCED SERVICES AND TECHNOLOGIES NOT TYPICALLY SEEN IN A COMMUNITY HOSPITAL, INCLUDING A 64-SLICE CT, DIGITAL MAMMOGRAPHY AND A FULL-TIME HOSPITALIST PROGRAM. BMCN WAS ONE OF THE FIRST COMMUNITY HOSPITALS IN THE NATION TO CONVERT TO AN ELECTRONIC MEDICAL RECORD SYSTEM. ALL PATIENTS ARE CARED FOR IN THE STATE-OF-THE-ART BERKMAN BUILDING, WHICH OFFERS 48 PRIVATE PATIENT SUITES INCLUDING INTENSIVE CARE. BMCN HAS A BUSY MATERNITY DEPARTMENT, DELIVERING 532 BABIES DURING THE PAST FISCAL YEAR. INPATIENT PEDIATRIC CARE IS PROVIDED BY WOLFSON CHILDREN'S HOSPITAL IN JACKSONVILLE, OUR SISTER HOSPITAL IN BAPTIST HEALTH SYSTEM, INC (BHS), AND THE ONLY PEDIATRIC SPECIALTY HOSPITAL IN THE AREA. THE MEDICAL STAFF INCLUDES HIGHLY TRAINED PHYSICIANS IN 24 DIFFERENT SPECIALTIES WHO PRACTICE LOCALLY, AND AS PART OF BHS, BMCN HAS ACCESS TO MANY ADDITIONAL SPECIALIZED PHYSICIANS, SERVICES, AND RESOURCES WHEN NEEDED. DURING THE FISCAL YEAR, THERE WERE 478 EMPLOYEES, 54 BEDS, 3,184 ADMISSIONS ACCOUNTING FOR 11,030 PATIENT DAYS, AND 28,207 EMERGENCY ROOM VISITS. AS PART OF BHS, THE REGION'S ONLY COMMUNITY-OWNED, FAITH-BASED HEALTHCARE SYSTEM, BMCN IS COMMITTED TO IMPROVING THE HEALTH OF EVERYONE IN ITS COMMUNITY, REGARDLESS OF THEIR ABILITY TO PAY. BMCN PROVIDED THE FOLLOWING UNCOMPENSATED CARE AND COMMUNITY BENEFIT FOR THE FISCAL YEAR ENDED SEPTEMBER 30, 2014: (1) CHARITY CARE, \$2.8 MILLION, (2) UNREIMBURSED MEDICARE COSTS, \$3.3 MILLION, AND (3) SPECIFIC COMMUNITY PROGRAMS, \$95 THOUSAND FOR A TOTAL OF \$6.1 MILLION OF UNCOMPENSATED CARE AND COMMUNITY BENEFIT. BMCN'S PRIMARY FOCUS IS ADDRESSING UNMET HEALTH NEEDS, PARTICULARLY AMONG VULNERABLE POPULATIONS WHO HAVE LIMITED RESOURCES AND ACCESS TO HEALTH CARE. BMCN HAS GONE BEYOND THE DELIVERY OF ESSENTIAL HEALTH CARE TO IMPROVE THE LIVES OF INDIVIDUALS AND THE OVERALL QUALITY OF LIFE IN OUR REGION. BAPTIST HEALTH'S COMMUNITY HEALTH COMMITTEE GUIDES THE COMMUNITY HEALTH EFFORTS. THIS COMMITTEE PROVIDES STRATEGIC DIRECTION RELATED TO COMMUNITY HEALTH ACTIVITIES AND ENSURES FOCUS ON KEY PRIORITIES THAT ALIGN WITH BAPTIST HEALTH'S MISSION. A CORNERSTONE OF OUR COMMITMENT TO THE COMMUNITY IS CARING FOR THE HEALTH OF VULNERABLE, UNINSURED AND UNDERSERVED PEOPLE AMONG US. ONE OF BMCN'S GUIDING PRINCIPLES OF COMMUNITY HEALTH IS TO COLLABORATE WITH OTHER LOCAL ORGANIZATIONS TO LEVERAGE OUR COLLECTIVE EXPERTISE AND STRENGTH FOR THE HEALTH BENEFITS OF THE COMMUNITY. THIS COLLABORATIVE APPROACH HELPS ENSURE EFFICIENCY AND AVOIDS DUPLICATION OF EFFORT, RESULTING IN ENHANCEMENT OF THE LIVES OF AREA RESIDENTS AT EVERY LIFE STAGE AND INCOME LEVEL. BMCN COMMUNITY HEALTH PRIORITIES CURRENTLY INCLUDE: (1) INCREASING ACCESS TO CARE FOR MEDICALLY UNDERSERVED PEOPLE, (2) PREVENTING AND MANAGING CHRONIC DISEASES, (3) ASSISTING VICTIMS OF DOMESTIC VIOLENCE, AND (4) HELPING OUR CHILDREN AND YOUTH. BMCN, INDIVIDUALLY AND THROUGH ITS RELATED AFFILIATE, SOUTHERN BAPTIST HOSPITAL OF FLORIDA, INC., PROVIDED THE FOLLOWING CHARITABLE DONATIONS TO THE NASSAU COUNTY COMMUNITY: \$65 THOUSAND DOLLARS FOR NASSAU COUNTY COUNCIL ON AGING TO SUPPORT A TRANSPORTATION PROGRAM FOR SENIOR CITIZENS, \$25 THOUSAND FOR THE NASSAU BOYS AND GIRLS CLUB, WHICH ASSISTS THE YOUTH OF THE LOCAL COMMUNITY, AND \$10 THOUSAND TO THE NASSAU COUNTY ECONOMIC DEVELOPMENT BOARD TO SUPPORT JOB GROWTH AND IMPROVE ECONOMIC CONDITIONS IN NASSAU COUNTY.

4b (Code) (Expenses \$) (Revenue \$)**4c** (Code) (Expenses \$) (Revenue \$)**4d** Other program services (Describe in Schedule O)
(Expenses \$) (Revenue \$)

including grants of \$

4e **Total program service expenses** ► 47,911,361

Part IV Checklist of Required Schedules

- 1** Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A
- 2** Is the organization required to complete Schedule B, *Schedule of Contributors* (see instructions)?
- 3** Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I
- 4** **Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II
- 5** Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III
- 6** Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I
- 7** Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II
- 8** Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III
- 9** Did the organization report an amount in Part X, line 21 for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV
- 10** Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? If "Yes," complete Schedule D, Part V
- 11** If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable
- a** Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI
- b** Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII
- c** Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII
- d** Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX
- e** Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X
- f** Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part XI
- 12a** Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII
- b** Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional
- 13** Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E
- 14a** Did the organization maintain an office, employees, or agents outside of the United States?
- b** Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV
- 15** Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? If "Yes," complete Schedule F, Parts II and IV
- 16** Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV
- 17** Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions)
- 18** Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II
- 19** Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III
- 20a** Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H
- b** If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?

	Yes	No
1	Yes	
2	Yes	
3		No
4		No
5		
6		No
7		No
8		No
9		No
10	Yes	
11a	Yes	
11b		No
11c		No
11d	Yes	
11e	Yes	
11f	Yes	
12a		No
12b	Yes	
13		No
14a		No
14b		No
15		No
16		No
17		No
18		No
19		No
20a	Yes	
20b	Yes	

Part IV Checklist of Required Schedules (continued)

- 21** Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or government on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II **21** Yes
- 22** Did the organization report more than \$5,000 of grants or other assistance to individuals in the United States on Part IX, column (A), line 2? If "Yes," complete Schedule I, Parts I and III **22** No
- 23** Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? If "Yes," complete Schedule J **23** Yes
- 24a** Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a **24a** Yes
- b** Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? **24b** No
- c** Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? **24c** No
- d** Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? **24d** No
- 25a** **Section 501(c)(3) and 501(c)(4) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? If "Yes," complete Schedule L, Part I **25a** No
- b** Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? If "Yes," complete Schedule L, Part I **25b** No
- 26** Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? If so, complete Schedule L, Part II **26** No
- 27** Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? If "Yes," complete Schedule L, Part III **27** No
- 28** Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)
- a** A current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV **28a** Yes
- b** A family member of a current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV **28b** No
- c** An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? If "Yes," complete Schedule L, Part IV **28c** No
- 29** Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M **29** No
- 30** Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M **30** No
- 31** Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I **31** No
- 32** Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II **32** No
- 33** Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? If "Yes," complete Schedule R, Part I **33** No
- 34** Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1 **34** Yes
- 35a** Did the organization have a controlled entity within the meaning of section 512(b)(13)?
- b** If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? If "Yes," complete Schedule R, Part V, line 2 **35b** No
- 36** **Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? If "Yes," complete Schedule R, Part V, line 2 **36** No
- 37** Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? If "Yes," complete Schedule R, Part VI **37** No
- 38** Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O **38** Yes

Part V Statements Regarding Other IRS Filings and Tax Compliance

Check if Schedule O contains a response or note to any line in this Part V

		Yes	No
1a Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable . . .	1a	58	
1b Enter the number of Forms W-2G included in line 1a Enter -0- if not applicable . . .	1b	0	
c Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? . . .	1c	Yes	
2a Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return . . .	2a	478	
b If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	2b	Yes	
3a Did the organization have unrelated business gross income of \$1,000 or more during the year? . . .	3a	Yes	
b If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O . . .	3b	Yes	
4a At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . . .	4a	No	
b If "Yes," enter the name of the foreign country ► See instructions for filing requirements for Form TD F 90-22 1, Report of Foreign Bank and Financial Accounts			
5a Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . .	5a	No	
b Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? . . .	5b	No	
c If "Yes," to line 5a or 5b, did the organization file Form 8886-T? . . .	5c		
6a Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . .	6a	No	
b If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? . . .	6b		
7 Organizations that may receive deductible contributions under section 170(c).			
a Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? . . .	7a	No	
b If "Yes," did the organization notify the donor of the value of the goods or services provided? . . .	7b		
c Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? . . .	7c	No	
d If "Yes," indicate the number of Forms 8282 filed during the year . . .	7d		
e Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? . . .	7e	No	
f Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . .	7f	No	
g If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? . . .	7g		
h If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? . . .	7h		
8 Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations. Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year? . . .	8		
9 Sponsoring organizations maintaining donor advised funds.			
a Did the organization make any taxable distributions under section 4966? . . .	9a		
b Did the organization make a distribution to a donor, donor advisor, or related person? . . .	9b		
10 Section 501(c)(7) organizations. Enter			
a Initiation fees and capital contributions included on Part VIII, line 12 . . .	10a		
b Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b		
11 Section 501(c)(12) organizations. Enter			
a Gross income from members or shareholders . . .	11a		
b Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them) . . .	11b		
12a Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041? . . .	12a		
b If "Yes," enter the amount of tax-exempt interest received or accrued during the year . . .	12b		
13 Section 501(c)(29) qualified nonprofit health insurance issuers.			
a Is the organization licensed to issue qualified health plans in more than one state? Note. See the instructions for additional information the organization must report on Schedule O	13a		
b Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans . . .	13b		
c Enter the amount of reserves on hand . . .	13c		
14a Did the organization receive any payments for indoor tanning services during the tax year? . . .	14a	No	
b If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O . . .	14b		

Part VI Governance, Management, and Disclosure For each "Yes" response to lines 2 through 7b below, and for a "No" response to lines 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.

Check if Schedule O contains a response or note to any line in this Part VI

Section A. Governing Body and Management

			Yes	No
1a Enter the number of voting members of the governing body at the end of the tax year	1a	13		
If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O				
b Enter the number of voting members included in line 1a, above, who are independent	1b	9		
2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		No	
3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	3		No	
4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		No	
5 Did the organization become aware during the year of a significant diversion of the organization's assets?	5		No	
6 Did the organization have members or stockholders?	6	Yes		
7a Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a	Yes		
b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b	Yes		
8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following	8a	Yes		
a The governing body?	8b	Yes		
b Each committee with authority to act on behalf of the governing body?	9	No		
9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O				

Section B. Policies (This Section B requests information about policies not required by the Internal Revenue Code.)

		Yes	No
10a Did the organization have local chapters, branches, or affiliates?	10a	No	
b If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b		
11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a	No	
b Describe in Schedule O the process, if any, used by the organization to review this Form 990			
12a Did the organization have a written conflict of interest policy? If "No," go to line 13	12a	Yes	
b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	Yes	
c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done	12c	Yes	
13 Did the organization have a written whistleblower policy?	13	Yes	
14 Did the organization have a written document retention and destruction policy?	14	Yes	
15 Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?	15a	Yes	
a The organization's CEO, Executive Director, or top management official	15b	Yes	
b Other officers or key employees of the organization			
If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions)			
16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a	No	
b If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b		

Section C. Disclosure

- 17 List the States with which a copy of this Form 990 is required to be filed
- 18 Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c) (3)s only) available for public inspection. Indicate how you made these available. Check all that apply
 Own website Another's website Upon request Other (explain in Schedule O)
- 19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year
- 20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization

Scott Finnegan 841 Prudential Dr Aetna Bldg 1602
Jacksonville, FL 32207 (904) 202-3270

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent ContractorsCheck if Schedule O contains a response or note to any line in this Part VII **Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees**

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year

• List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid• List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."• List the organization's five **current** highest compensated employees (other than an officer, director, trustee or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations• List all of the organization's **former** officers, key employees, or highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations• List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations

List persons in the following order: individual trustees or directors, institutional trustees, officers, key employees, highest compensated employees, and former such persons

 Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099- MISC)	(E) Reportable compensation from related organizations (W-2/1099- MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Office	Key Employee	Highest Compensated	Former			
(1) A HUGH GREENE President & Director	0 00 40 00	X		X				0	1,072,886	514,891
(2) JON C LASERRE Secretary/Treasurer & Director	2 00 0	X		X				0	0	0
(3) RICHARD W KEFFER Chairman & Director	2 00 0	X		X				0	0	0
(4) CHRISTINA H BRYAN Vice Chairman & Director	2 00 0	X						0	0	0
(5) DONNA L VANPUYMBROUCK Director	2 00 0	X						0	0	0
(6) GERALD R BURFORD MD Director	2 00 0	X						0	0	0
(7) GREGORY N SMITH MD Director	2 00 0	X						0	0	0
(8) JAMES M TOWNSEND Director	1 00 1 00	X						0	0	0
(9) JANICE ANCRUM Director	2 00 0	X						0	0	0
(10) KATHERINE MONAHAN Director	2 00 0	X						0	0	0
(11) MICHAEL M BELL Director	2 00 0	X						0	0	0
(12) ROBERT FERREIRA Director	2 00 0	X						0	0	0
(13) WILLIAM H GOWER Director	2 00 0	X						0	0	0
(14) WILLIE J SCOTT Director	2 00 0	X						0	0	0
(15) HARVEY GRANGER Assistant Secretary	0 00 40 00		X					0	486,616	215,282
(16) JOHN F WILBANKS Executive VP	0 00 40 00		X					0	634,992	241,332
(17) SCOTT WOOTEN SVP/CFO	0 00 40 00		X					0	50,000	0

Part VII **Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees (continued)**

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization **10**

		Yes	No
3	Did the organization list any former officer, director or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i>	3	No
4	For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? <i>If "Yes," complete Schedule J for such individual</i>	4	Yes
5	Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? <i>If "Yes," complete Schedule J for such person</i>	5	No

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than \$100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation
BAPTIST PRIMARY CARE INC 3563 PHILIPS HWY BLDG A STE 101 JACKSONVILLE FL 32207	HOSPITALIST SERVICES FOR THE HOSPITAL	974,400
AMELIA ANESTHESIA PL 1250 S 18TH ST FERNANDINA BEACH FL 32034	ANESTHESIA SERVICES FOR THE HOSPITAL	281,285
CROWN HEALTH CARE LAUNDRY SERVICE INC 1501 N GUILLEMARD PENSACOLA FL 32501	LAUNDRY SERVICES FOR THE HOSPITAL	272,918
SODEXHO INC & AFFILIATES PPO BOX 536922 ATLANTA GA 303536922	RESTAURANT AND HOUSEKEEPING SERVICES FOR THE HOSPITAL	252,711

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization **24**

Part VIII Statement of RevenueCheck if Schedule O contains a response or note to any line in this Part VIII

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a				
	b Membership dues	1b				
	c Fundraising events	1c				
	d Related organizations	1d	94,464			
	e Government grants (contributions)	1e				
	f All other contributions, gifts, grants, and similar amounts not included above	1f				
	g Noncash contributions included in lines 1a-1f \$					
	h Total. Add lines 1a-1f		94,464			
Program Service Revenue	Business Code					
	2a NET PATIENT SERVICE REVENUES	622000	64,853,989	64,853,989	0	0
	b EHR REVENUE MEDICARE	622000	1,006,971	1,006,971	0	0
	c EHR REVENUE MEDICAID	622000	78,159	78,159	0	0
	d		0			
	e		0			
	f All other program service revenue		0	0	0	0
	g Total. Add lines 2a-2f		65,939,119			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		802,355	0	0	802,355
	4 Income from investment of tax-exempt bond proceeds		0			
	5 Royalties		0			
	(I) Real (II) Personal					
	6a Gross rents	232,390	0			
	b Less rental expenses	0	0			
	c Rental income or (loss)	232,390	0			
	d Net rental income or (loss)		232,390	232,390	0	0
(I) Securities (II) Other						
7a Gross amount from sales of assets other than inventory						
b Less cost or other basis and sales expenses						
c Gain or (loss)	0	0				
d Net gain or (loss)		0				
8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18						
b Less direct expenses	a					
c Net income or (loss) from fundraising events		0				
9a Gross income from gaming activities See Part IV, line 19	a					
b Less direct expenses	a					
c Net income or (loss) from gaming activities		0				
10a Gross sales of inventory, less returns and allowances	a					
b Less cost of goods sold	a					
c Net income or (loss) from sales of inventory		0				
Miscellaneous Revenue		Business Code				
11a RESTAURANT REVENUE	722212	263,330			263,330	
b GAINS ON INTEREST RATE SWAPS	523000	74,495	74,495	0	0	
c REFERENCE LAB REVENUES	621500	31,008	18,529	12,479	0	
d All other revenue		61,127	0	0	61,127	
e Total. Add lines 11a-11d		429,960				
12 Total revenue. See Instructions		67,498,288	66,264,533	12,479	1,126,812	

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns All other organizations must complete column (A)

Check if Schedule O contains a response or note to any line in this Part IX

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the United States See Part IV, line 21	46,125	46,125		
2 Grants and other assistance to individuals in the United States See Part IV, line 22	0	0		
3 Grants and other assistance to governments, organizations, and individuals outside the United States See Part IV, lines 15 and 16	0	0		
4 Benefits paid to or for members	0	0		
5 Compensation of current officers, directors, trustees, and key employees . . .	307,851	0	307,851	0
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) . . .	0	0	0	0
7 Other salaries and wages	17,385,141	16,685,446	699,695	0
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions) . . .	1,232,192	1,194,022	38,170	0
9 Other employee benefits . . .	3,895,651	3,692,391	203,260	0
10 Payroll taxes . . .	1,324,971	1,283,221	41,750	0
11 Fees for services (non-employees)				
a Management . . .	2,165,278	1,515,763	649,515	0
b Legal . . .	39,752	27,827	11,925	0
c Accounting . . .	17,012	11,908	5,104	0
d Lobbying . . .	0	0	0	0
e Professional fundraising services See Part IV, line 17	0			0
f Investment management fees . . .	0	0	0	0
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O) . . .	731,193	731,193	0	0
12 Advertising and promotion . . .	45,599	45,599	0	0
13 Office expenses . . .	7,508,934	7,353,893	155,041	0
14 Information technology . . .	905,157	905,157	0	0
15 Royalties . .	0	0	0	0
16 Occupancy . . .	2,332,176	2,332,176	0	0
17 Travel . . .	65,008	65,008	0	0
18 Payments of travel or entertainment expenses for any federal, state, or local public officials . . .	0	0	0	0
19 Conferences, conventions, and meetings . . .	114,417	114,417	0	0
20 Interest . . .	44,557	44,557	0	0
21 Payments to affiliates . . .	0	0	0	0
22 Depreciation, depletion, and amortization . . .	3,103,563	3,103,563	0	0
23 Insurance . . .	870,781	870,781	0	0
24 Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24e If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O)				
a SYSTEM FUNCTION ALLOCATION	7,236,523	6,945,615	290,908	0
b AHCA AND NICA ASSESSMENTS	717,115	717,115	0	0
c DUES AND MEMBERSHIPS	60,074	42,052	18,022	0
d LICENSES & FEES	107,644	53,822	53,822	0
e All other expenses	185,300	129,710	55,590	0
25 Total functional expenses. Add lines 1 through 24e	50,442,014	47,911,361	2,530,653	0
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation Check here ► if following SOP 98-2 (ASC 958-720)	0			

Part X Balance SheetCheck if Schedule O contains a response or note to any line in this Part X

		(A) Beginning of year	(B) End of year
Assets			
1	Cash—non-interest-bearing	600	1
2	Savings and temporary cash investments	2	
3	Pledges and grants receivable, net	3	
4	Accounts receivable, net	6,988,169	4
5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L		
		0	5
6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L		
		0	6
7	Notes and loans receivable, net	7	
8	Inventories for sale or use	737,184	8
9	Prepaid expenses and deferred charges	457,013	9
10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	10a	72,548,993
b	Less accumulated depreciation	10b	35,076,040
		37,503,763	10c
11	Investments—publicly traded securities	8,846,384	11
12	Investments—other securities See Part IV, line 11	0	12
13	Investments—program-related See Part IV, line 11	0	13
14	Intangible assets		14
15	Other assets See Part IV, line 11	43,075,522	15
16	Total assets. Add lines 1 through 15 (must equal line 34)	97,608,635	16
			110,049,071
Liabilities			
17	Accounts payable and accrued expenses	5,058,677	17
18	Grants payable	0	18
19	Deferred revenue		19
20	Tax-exempt bond liabilities	4,714,454	20
21	Escrow or custodial account liability Complete Part IV of Schedule D		21
22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L		
		0	22
23	Secured mortgages and notes payable to unrelated third parties		23
24	Unsecured notes and loans payable to unrelated third parties		24
25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24) Complete Part X of Schedule D		
		500,385	25
26	Total liabilities. Add lines 17 through 25	10,273,516	26
			10,649,621
Net Assets or Fund Balances			
	Organizations that follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.		
27	Unrestricted net assets	87,007,756	27
28	Temporarily restricted net assets	234,568	28
29	Permanently restricted net assets	92,795	29
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.		
30	Capital stock or trust principal, or current funds		30
31	Paid-in or capital surplus, or land, building or equipment fund		31
32	Retained earnings, endowment, accumulated income, or other funds		32
33	Total net assets or fund balances	87,335,119	33
34	Total liabilities and net assets/fund balances	97,608,635	34
			110,049,071

Part XI Reconciliation of Net AssetsCheck if Schedule O contains a response or note to any line in this Part XI

1	Total revenue (must equal Part VIII, column (A), line 12)	1	67,498,288
2	Total expenses (must equal Part IX, column (A), line 25)	2	50,442,014
3	Revenue less expenses Subtract line 2 from line 1	3	17,056,274
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	87,335,119
5	Net unrealized gains (losses) on investments	5	23,861
6	Donated services and use of facilities	6	0
7	Investment expenses	7	0
8	Prior period adjustments	8	0
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-5,069,626
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	99,399,450

Part XII Financial Statements and ReportingCheck if Schedule O contains a response or note to any line in this Part XII

	Yes	No
1 Accounting method used to prepare the Form 990 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O		
2a Were the organization's financial statements compiled or reviewed by an independent accountant? If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	2a	No
2b Were the organization's financial statements audited by an independent accountant? If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	2b	Yes
2c If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O	2c	Yes
3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a	No
3b If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	3b	

SCHEDULE A
(Form 990 or 990EZ)**Public Charity Status and Public Support**

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

2013**Open to Public
Inspection**Department of the
Treasury
Internal Revenue Service

► Attach to Form 990 or Form 990-EZ. ► See separate instructions.

► Information about Schedule A (Form 990 or 990-EZ) and its instructions is at
www.irs.gov/form990.**Name of the organization**

BAPTIST MEDICAL CENTER OF NASSAU INC

Employer identification number

59-3234721

Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is (For lines 1 through 11, check only one box)

- 1 A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i)**.
- 2 A school described in **section 170(b)(1)(A)(ii)**. (Attach Schedule E)
- 3 A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii)**.
- 4 A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii)**. Enter the hospital's name, city, and state _____
- 5 An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv)**. (Complete Part II)
- 6 A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v)**.
- 7 An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi)**. (Complete Part II)
- 8 A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II)
- 9 An organization that normally receives (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2)**. (Complete Part III)
- 10 An organization organized and operated exclusively to test for public safety See **section 509(a)(4)**.
- 11 An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2) See **section 509(a)(3)**. Check the box that describes the type of supporting organization and complete lines 11e through 11h
- e a Type I b Type II c Type III - Functionally integrated d Type III - Non-functionally integrated
- f If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box
- g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?
- (i) A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization?
- (ii) A family member of a person described in (i) above?
- (iii) A 35% controlled entity of a person described in (i) or (ii) above?
- h Provide the following information about the supported organization(s)

	Yes	No
11g(i)		
11g(ii)		
11g(iii)		

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1- 9 above or IRC section (see instructions))	(iv) Is the organization in col (i) listed in your governing document?		(v) Did you notify the organization in col (i) of your support?		(vi) Is the organization in col (i) organized in the U S ?		(vii) Amount of monetary support
			Yes	No	Yes	No	Yes	No	
Total									

Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 Public support. Subtract line 5 from line 4						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income Do not include gain or loss from the sale of capital assets (Explain in Part IV)						
11 Total support (Add lines 7 through 10)						
12 Gross receipts from related activities, etc (see instructions)					12	
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a 501(c)(3) organization, check this box and stop here ►						

Section C. Computation of Public Support Percentage

14 Public support percentage for 2013 (line 6, column (f) divided by line 11, column (f))	14	
15 Public support percentage for 2012 Schedule A, Part II, line 14	15	
16a 33 1/3% support test—2013. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here . The organization qualifies as a publicly supported organization ►		
b 33 1/3% support test—2012. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here . The organization qualifies as a publicly supported organization ►		
17a 10%-facts-and-circumstances test—2013. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here . Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ►		
b 10%-facts-and-circumstances test—2012. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here . Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ►		
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ►		

Part III Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 Public support (Subtract line 7c from line 6)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income Do not include gain or loss from the sale of capital assets (Explain in Part IV)						
13 Total support. (Add lines 9, 10c, 11, and 12)						
14 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a 501(c)(3) organization, check this box and stop here ►						

Section C. Computation of Public Support Percentage

15 Public support percentage for 2013 (line 8, column (f) divided by line 13, column (f))	15
16 Public support percentage from 2012 Schedule A, Part III, line 15	16

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2013 (line 10c, column (f) divided by line 13, column (f))	17
18 Investment income percentage from 2012 Schedule A, Part III, line 17	18
19a 33 1/3% support tests—2013. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and stop here . The organization qualifies as a publicly supported organization ►	
b 33 1/3% support tests—2012. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and stop here . The organization qualifies as a publicly supported organization ►	
20 Private foundation. If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ►	

Part IV Supplemental Information. Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; and Part III, line 12. Also complete this part for any additional information. (See instructions).**Facts And Circumstances Test**

Return Reference

Explanation

2013

Open to Public
Inspection**SCHEDULE D**
(Form 990)**Supplemental Financial Statements**► Complete if the organization answered "Yes," to Form 990,
Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b► Attach to Form 990. ► See separate instructions. ► Information about Schedule D (Form 990)
and its instructions is at www.irs.gov/form990.Department of the Treasury
Internal Revenue Service**Name of the organization**

BAPTIST MEDICAL CENTER OF NASSAU INC

Employer identification number

59-3234721

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" to Form 990, Part IV, line 6.

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year		
2 Aggregate contributions to (during year)		
3 Aggregate grants from (during year)		
4 Aggregate value at end of year		

- 5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? Yes No
- 6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? Yes No

Part II Conservation Easements. Complete if the organization answered "Yes" to Form 990, Part IV, line 7.

- 1 Purpose(s) of conservation easements held by the organization (check all that apply)
- Preservation of land for public use (e.g., recreation or education) Preservation of an historically important land area
- Protection of natural habitat Preservation of a certified historic structure
- Preservation of open space
- 2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year
- | | Held at the End of the Year |
|----|-----------------------------|
| 2a | |
| 2b | |
| 2c | |
| 2d | |
- 3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ► _____
- 4 Number of states where property subject to conservation easement is located ► _____
- 5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? Yes No
- 6 Staff and volunteer hours devoted to monitoring, inspecting, and enforcing conservation easements during the year
► _____
- 7 Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year
► \$ _____
- 8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? Yes No
- 9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.
Complete if the organization answered "Yes" to Form 990, Part IV, line 8.

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items

(i) Revenues included in Form 990, Part VIII, line 1 ► \$ _____

(ii) Assets included in Form 990, Part X ► \$ _____

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items

a Revenues included in Form 990, Part VIII, line 1 ► \$ _____

b Assets included in Form 990, Part X ► \$ _____

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets (continued)

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply)

- | | |
|---|---|
| a <input type="checkbox"/> Public exhibition | d <input type="checkbox"/> Loan or exchange programs |
| b <input type="checkbox"/> Scholarly research | e <input type="checkbox"/> Other |
| c <input type="checkbox"/> Preservation for future generations | |

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII

5 During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? Yes No

Part IV Escrow and Custodial Arrangements. Complete if the organization answered "Yes" to Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? Yes No

b If "Yes," explain the arrangement in Part XIII and complete the following table

	Amount
1c	
1d	
1e	
1f	

2a Did the organization include an amount on Form 990, Part X, line 21? Yes No

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII.

Part V Endowment Funds. Complete if the organization answered "Yes" to Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	212,505	192,857	107,166	71,794	66,966
b Contributions	401,162	710	56,024	36,186	0
c Net investment earnings, gains, and losses	23,860	20,938	31,667	286	6,500
d Grants or scholarships	0	0	0	1,100	1,672
e Other expenditures for facilities and programs	759	2,000	2,000	0	0
f Administrative expenses	0	0	0	0	0
g End of year balance	636,768	212,505	192,857	107,166	71,794

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as

a Board designated or quasi-endowment ► 15 700 %

b Permanent endowment ► 76 900 %

c Temporarily restricted endowment ► 7 400 %

The percentages in lines 2a, 2b, and 2c should equal 100%

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by

(i) unrelated organizations

(ii) related organizations

b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?

	Yes	No
3a(i)		
3a(ii)	Yes	
3b		

4 Describe in Part XIII the intended uses of the organization's endowment funds

Part VI Land, Buildings, and Equipment. Complete if the organization answered 'Yes' to Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

	Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		477,107			477,107
b Buildings		40,696,781	13,025,084		27,671,697
c Leasehold improvements		84,649	31,957		52,692
d Equipment		28,176,757	21,192,098		6,984,659
e Other		3,113,699	826,901		2,286,798
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c).)					37,472,953

Part VII Investments—Other Securities. Complete if the organization answered 'Yes' to Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
Other		
		</td

Total. (Column (b) must equal Form 990, Part X, col (B) line 12)

Part VIII Investments—Program Related. Complete if the organization answered 'Yes' to Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

Total. (Column (b) must equal Form 990, Part X, col (B), line 13.)

Part IX Other Assets. Complete if the organization answered 'Yes' to Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

Total. (Column (b) must equal Form 990, Part X, col.(B) line 15.)

52,304,676

Part X Other Liabilities. Complete if the organization answered 'Yes' to Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25.

1	(a) Description of liability	(b) Book value
Federal income taxes		
ESTIMATED THIRD-PARTY SETTLEMENTS		497,650
1997A BOND SWAP MARKET VALUE		307,481
2001 BOND SWAP MARKET VALUE		118,400
Total. (Column (b) must equal Form 990, Part X, col (B) line 25)		923,541

2. Liability for uncertain tax positions In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740). Check here if the text of the footnote has been provided in Part XIII.

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return Complete if the organization answered 'Yes' to Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements	1	
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12		
a	Net unrealized gains on investments	2a	
b	Donated services and use of facilities	2b	
c	Recoveries of prior year grants	2c	
d	Other (Describe in Part XIII)	2d	
e	Add lines 2a through 2d	2e	
3	Subtract line 2e from line 1	3	
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIII)	4b	
c	Add lines 4a and 4b	4c	
5	Total revenue Add lines 3 and 4c. (This must equal Form 990, Part I, line 12)	5	

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return. Complete if the organization answered 'Yes' to Form 990, Part IV, line 12a.

1	Total expenses and losses per audited financial statements	1	
2	Amounts included on line 1 but not on Form 990, Part IX, line 25		
a	Donated services and use of facilities	2a	
b	Prior year adjustments	2b	
c	Other losses	2c	
d	Other (Describe in Part XIII)	2d	
e	Add lines 2a through 2d	2e	
3	Subtract line 2e from line 1	3	
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIII)	4b	
c	Add lines 4a and 4b	4c	
5	Total expenses Add lines 3 and 4c. (This must equal Form 990, Part I, line 18)	5	

Part XIII Supplemental Information

Provide the descriptions required for Part II, lines 3, 5, and 9, Part III, lines 1a and 4, Part IV, lines 1b and 2b, Part V, line 4, Part X, line 2, Part XI, lines 2d and 4b, and Part XII, lines 2d and 4b. Also complete this part to provide any additional information

Return Reference	Explanation
Schedule D, Part V, Line 4, Intended uses of endowment funds	BAPTIST MEDICAL CENTER OF NASSAU INC (BMCN) HAS TEMPORARY RESTRICTED QUASI-ENDOWMENT FUND AND PERMANENTLY RESTRICTED ENDOWMENT FUNDS THAT ARE HELD AND ADMINISTERED BY ITS RELATED FUNDRAISING AFFILIATED ORGANIZATION, BAPTIST HEALTH SYSTEM FOUNDATION, INC ANNUALLY, 5% OF THE COMBINED ENDOWMENT CORPUS AND ACCUMULATED INVESTMENT EARNINGS ARE AVAILABLE FOR CAPITAL PROJECTS OF BMCN
Schedule D, Part X, Line 2, FIN 48 (ASC 740) footnote	NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (DOLLARS IN THOUSANDS) 9. INCOME TAXES DEFERRED INCOME TAXES, WHICH AS OF SEPTEMBER 30, 2014 AND 2013, HAVE NO NET CARRYING VALUE, REFLECT THE NET TAX EFFECT OF TEMPORARY DIFFERENCES BETWEEN THE CARRYING AMOUNTS OF ASSETS AND LIABILITIES FOR FINANCIAL REPORTING AND THE AMOUNTS USED FOR INCOME TAX PURPOSES AS OF SEPTEMBER 30, 2014 AND 2013, BHS HAD DEFERRED TAX ASSETS OF \$24,358 AND \$22,388, RESPECTIVELY, RELATING PRINCIPALLY TO NET OPERATING LOSS CARRYOVERS ASC 740-10-50-3, INCOME TAXES DISCLOSURE, REQUIRES A VALUATION ALLOWANCE TO REDUCE THE DEFERRED TAX ASSETS REPORTED IF, BASED ON THE WEIGHT OF THE EVIDENCE, IT IS MORE LIKELY THAN NOT THAT SOME PORTION OR ALL OF THE DEFERRED TAX ASSETS WILL NOT BE REALIZED AFTER CONSIDERATION OF ALL THE EVIDENCE, BOTH POSITIVE AND NEGATIVE, MANAGEMENT DETERMINED THAT A \$24,358 AND \$22,388 ALLOWANCE AT SEPTEMBER 30, 2014 AND 2013, RESPECTIVELY, WAS NECESSARY TO REDUCE THE DEFERRED TAX ASSETS TO THE AMOUNT THAT WOULD MORE LIKELY THAN NOT BE REALIZED. THE CHANGE IN THE VALUATION ALLOWANCE FOR THE CURRENT YEAR IS \$1,970 AT SEPTEMBER 30, 2014, BHS HAS AVAILABLE NET OPERATING LOSS CARRYFORWARDS OF \$64,729 THESE NET OPERATING LOSSES WILL EXPIRE BETWEEN 2018 AND 2034

Part XIII Supplemental Information (continued)

Return Reference	Explanation

SCHEDULE H
(Form 990)

Hospitals

OMB No 1545-0047

Department of the Treasury
Internal Revenue Service

► Complete if the organization answered "Yes" to Form 990, Part IV, question 20.

► Attach to Form 990. ► See separate instructions.

► Information about Schedule H (Form 990) and its instructions is at www.irs.gov/form990.

2013

Open to Public
Inspection

Name of the organization

BAPTIST MEDICAL CENTER OF NASSAU INC

Employer identification number

59-3234721

Part I Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a Yes	
b If "Yes," was it a written policy?	1b Yes	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year		
<input checked="" type="checkbox"/> Applied uniformly to all hospital facilities	Applied uniformly to most hospital facilities	
<input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year		
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for <i>free</i> care	3a Yes	
<input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %		
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for <i>discounted</i> care	3b Yes	
<input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input checked="" type="checkbox"/> 400% <input type="checkbox"/> Other _____ %		
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4 Yes	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a Yes	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b Yes	
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c No	
6a Did the organization prepare a community benefit report during the tax year?	6a Yes	
b If "Yes," did the organization make it available to the public?	6b Yes	
Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H		

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			2,779,080	0	2,779,080	5 510 %
b Medicaid (from Worksheet 3, column a)			6,841,525	7,130,282	-288,757	0 %
c Costs of other means-tested government programs (from Worksheet 3, column b)			0	0	0	0 %
d Total Financial Assistance and Means-Tested Government Programs	0	0	9,620,605	7,130,282	2,490,323	5 510 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)					0	0 %
f Health professions education (from Worksheet 5)					0	0 %
g Subsidized health services (from Worksheet 6)					0	0 %
h Research (from Worksheet 7)					0	0 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)			53,687		53,687	0 110 %
j Total Other Benefits	0	0	53,687	0	53,687	0 110 %
k Total Add lines 7d and 7j	0	0	9,674,292	7,130,282	2,544,010	5 620 %

Part II Community Building Activities Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing					0	0 %
2 Economic development					0	0 %
3 Community support	1				0	0 %
4 Environmental improvements					0	0 %
5 Leadership development and training for community members					0	0 %
6 Coalition building	2				0	0 %
7 Community health improvement advocacy	4				0	0 %
8 Workforce development					0	0 %
9 Other					0	0 %
10 Total	7	0	0	0	0	0 %

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

- 1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No 15? **1**
- 2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount **2** 2,345,412
- 3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit **3** 0
- 4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements

Section B. Medicare

- 5 Enter total revenue received from Medicare (including DSH and IME) **5** 18,832,973
- 6 Enter Medicare allowable costs of care relating to payments on line 5 **6** 22,105,561
- 7 Subtract line 6 from line 5. This is the surplus (or shortfall) **7** -3,272,588
- 8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used

Cost accounting system

Cost to charge ratio

Other

Section C. Collection Practices

- 9a Did the organization have a written debt collection policy during the tax year? **9a** Yes
- b If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI **9b** Yes

Part IV Management Companies and Joint Ventures (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

	(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

Part V Facility Information

Section A. Hospital Facilities

(list in order of size from largest to smallest—see instructions)

How many hospital facilities did the organization operate during the tax year?

1

Name, address, primary website address,
and state license number

Part V Facility Information (continued)**Section B. Facility Policies and Practices**

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

BAPTIST MEDICAL CENTER OF NASSAU INC

Name of hospital facility or facility reporting group _____**If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A)** _____ 1 _____

Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)		Yes	No
1	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9	1 Yes	
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j	<input type="checkbox"/> Other (describe in Part VI)		
2	Indicate the tax year the hospital facility last conducted a CHNA 20 12		
3	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted.	3 Yes	
4	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4 Yes	
5	Did the hospital facility make its CHNA report widely available to the public?	5 Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply)		
a	<input checked="" type="checkbox"/> Hospital facility's website (list url) <u>www.baptistjax.com</u>		
b	<input checked="" type="checkbox"/> Other website (list url) <u>http://ufhealthjax.org</u>		
c	<input checked="" type="checkbox"/> Available upon request from the hospital facility		
d	<input type="checkbox"/> Other (describe in Part VI)		
6	If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year)		
a	<input checked="" type="checkbox"/> Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA		
b	<input checked="" type="checkbox"/> Execution of the implementation strategy		
c	<input checked="" type="checkbox"/> Participation in the development of a community-wide plan		
d	<input checked="" type="checkbox"/> Participation in the execution of a community-wide plan		
e	<input checked="" type="checkbox"/> Inclusion of a community benefit section in operational plans		
f	<input checked="" type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the CHNA		
g	<input checked="" type="checkbox"/> Prioritization of health needs in its community		
h	<input checked="" type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
i	<input type="checkbox"/> Other (describe in Part VI)		
7	Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7 No	
8a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	8a No	
b	If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	8b	
c	If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)

Financial Assistance Policy		Yes	No
9	Did the hospital facility have in place during the tax year a written financial assistance policy that explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	9	Yes
10	Used federal poverty guidelines (FPG) to determine eligibility for providing <i>free</i> care? If "Yes," indicate the FPG family income limit for eligibility for free care <u>200%</u> If "No," explain in Part VI the criteria the hospital facility used	10	Yes
11	Used FPG to determine eligibility for providing <i>discounted</i> care? If "Yes," indicate the FPG family income limit for eligibility for discounted care <u>400%</u> If "No," explain in Part VI the criteria the hospital facility used	11	Yes
12	Explained the basis for calculating amounts charged to patients? If "Yes," indicate the factors used in determining such amounts (check all that apply)	12	Yes
a	<input checked="" type="checkbox"/> Income level		
b	<input checked="" type="checkbox"/> Asset level		
c	<input checked="" type="checkbox"/> Medical indigency		
d	<input checked="" type="checkbox"/> Insurance status		
e	<input checked="" type="checkbox"/> Uninsured discount		
f	<input checked="" type="checkbox"/> Medicaid/Medicare		
g	<input checked="" type="checkbox"/> State regulation		
h	<input checked="" type="checkbox"/> Residency		
i	<input type="checkbox"/> Other (describe in Part VI)		
13	Explained the method for applying for financial assistance?	13	Yes
14	Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	14	Yes
a	<input type="checkbox"/> The policy was posted on the hospital facility's website		
b	<input type="checkbox"/> The policy was attached to billing invoices		
c	<input type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms		
d	<input type="checkbox"/> The policy was posted in the hospital facility's admissions offices		
e	<input type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility		
f	<input checked="" type="checkbox"/> The policy was available upon request		
g	<input type="checkbox"/> Other (describe in Part VI)		

Billing and Collections

15	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	15	Yes
16	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
a	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		
17	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged	17	No
a	<input type="checkbox"/> Reporting to credit agency		
b	<input type="checkbox"/> Lawsuits		
c	<input type="checkbox"/> Liens on residences		
d	<input type="checkbox"/> Body attachments		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		

Part V Facility Information (continued)

18 Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply)

- a Notified individuals of the financial assistance policy on admission
- b Notified individuals of the financial assistance policy prior to discharge
- c Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- d Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- e Other (describe in Section C)

Policy Relating to Emergency Medical Care

19 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?

If "No," indicate why

- a The hospital facility did not provide care for any emergency medical conditions
- b The hospital facility's policy was not in writing
- c The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)
- d Other (describe in Part VI)

	Yes	No
19 Yes		

Charges to Individuals Eligible for Assistance under the FAP (FAP-Eligible Individuals)

20 Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

- a The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d Other (describe in Part VI)

21		No

21 During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care?

If "Yes," explain in Part VI

22 During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?

If "Yes," explain in Part VI

22		No

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1J, 3, 4, 5d, 6I, 7, 10, 11, 12I, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
See Additional Data Table	

Schedule H (Form 990) 2013

Part V Facility Information (continued)**Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**
(list in order of size, from largest to smallest)How many non-hospital health care facilities did the organization operate during the tax year? **0**

Name and address	Type of Facility (describe)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Part VI Supplemental Information

Provide the following information

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II and Part III, lines 2, 3, 4, 8 and 9b
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNA's reported in Part V, Section B
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.)
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report

Form and Line Reference	Explanation
Schedule H, Part I, Line 6a, Community benefit report prepared by related organization	BAPTIST HEALTH SYSTEM, INC

Form and Line Reference	Explanation
Schedule H, Part I, Line 7, Costing Methodology used to calculate financial assistance	THE ORGANIZATION USES A COST-TO-CHARGE RATIO BASED ON ITS COST ACCOUNTING SYSTEM

Form and Line Reference	Explanation
Schedule H, Part I, Line 7, col(f), Bad Debt Expense excluded from financial assistance calculation	0

Form and Line Reference	Explanation
Schedule H, Part I, Line 7g, Subsidized Health Services	N/A

Form and Line Reference	Explanation
Schedule H, Part II, Community Building Activities	<p>LINE 3 COMMUNITY SUPPORT (1) SUMMER YOUTH VOLUNTEER PROGRAM - BAPTIST HEALTH OFFERS OPPORTUNITIES FOR APPROXIMATELY 15 YOUNG PEOPLE AGES 16-17 TO VOLUNTEER DURING THE SUMMER TO ASSIST IN THE SELECTION OF A CAREER AND AS AN OPPORTUNITY TO SERVE OTHERS BAPTIST EMPLOYEES SUPERVISE THE VOLUNTEERS GIVING THEM DIRECTION AND SUPPORT DURING THEIR SERVICE</p> <p>LINE 6 COALITION BUILDING (1) JACKSONVILLE METROPOLITAN COMMUNITY BENEFIT PARTNERSHIP CAME TOGETHER TO DEVELOP A MULTI-HOSPITAL SYSTEM AND PUBLIC HEALTH SECTOR COLLABORATIVE COMMUNITY HEALTH NEEDS ASSESSMENT THE PARTNERSHIP IS A NETWORK OF FIVE HOSPITALS AND FOUR PUBLIC HEALTH DEPARTMENTS THAT ARE A SHARED VOICE TO IMPROVE POPULATION HEALTH BY ELIMINATING THE GAPS THAT PREVENT QUALITY, INTEGRATED HEALTH CARE AND TO IMPROVE ACCESS TO RESOURCES THAT SUPPORT A HEALTHIER LIFESTYLE</p> <p>(2) NASSAU COMMUNITY HEALTH IMPROVEMENT COALITION - BAPTIST MEDICAL CENTER OF NASSAU IS A MEMBER OF THE NASSAU COMMUNITY HEALTH IMPROVEMENT COALITION (NCHIC) NCHIC IS A COALITION OF LOCAL AGENCIES, ORGANIZATIONS, COMMUNITY GROUPS, AND COMMUNITY MEMBERS WITH THE COMMON GOAL OF IMPROVING THE OVERALL HEALTH OF THE NASSAU COUNTY COMMUNITY THE COALITION WORKS TO IMPROVE THE LEVEL OF HEALTH IN NASSAU COUNTY THROUGH AWARENESS, EDUCATION, PARTNERSHIP, PREVENTION, SERVICE DELIVERY, AND POLICY DEVELOPMENT SO THAT INDIVIDUALS ACHIEVE THEIR POTENTIAL TO LIVE HEALTHY, ACTIVE LIFESTYLES</p> <p>LINE 7 COMMUNITY HEALTH IMPROVEMENT ADVOCACY (1) IN PARTNERSHIP WITH BARNABAS CENTER NASSAU, BAPTIST NASSAU WORKS TO PROVIDE ACCESS TO PRIMARY HEALTH CARE FOR PEOPLE WHO ARE UNINSURED AND UNDERINSURED (2) BAPTIST MEDICAL CENTER SUPPORTS ACCESS TO MENTAL HEALTH SERVICES IN PARTNERSHIP WITH STARTING POINT BEHAVIORAL HEALTH TO PROVIDE MENTAL HEALTH FIRST AID THAT TEACHES PARTICIPANTS A FIVE-STEP ACTION PLAN TO ASSESS A SITUATION, SELECT AND IMPLEMENT INTERVENTIONS AND SECURE APPROPRIATE CARE FOR THE INDIVIDUAL (3) BAPTIST NASSAU PARTNERS WITH THE NASSAU COUNTY COUNCIL ON AGING TO SUPPORT THE PROVISION OF TRANSPORTATION PROGRAM FOR THE ELDERLY IN A COMMUNITY WHERE NO PUBLIC TRANSPORTATION IS AVAILABLE (4) BAPTIST NASSAU ALSO PARTNERS WITH THE BOYS AND GIRLS CLUB OF NASSAU COUNTY TO PROVIDE POSITIVE YOUTH DEVELOPMENT ACTIVITIES THE GOALS OF WHICH ARE TO HELP STUDENTS BE SUCCESSFUL IN SCHOOL AND LIFE INCLUDING ON-TIME GRADUATION FROM HIGH SCHOOL</p>

Form and Line Reference	Explanation
Schedule H, Part III, Line 2, Bad debt expense - methodology used to estimate amount	<p>PATIENT SERVICE REVENUES ARE REPORTED AT ESTIMATED NET REALIZABLE AMOUNTS FOR SERVICES RENDERED BHS RECOGNIZES PATIENT SERVICE REVENUES ASSOCIATED WITH PATIENTS WHO HAVE THIRD-PARTY PAYOR COVERAGE ON THE BASIS OF CONTRACTUAL RATES FOR THE SERVICES RENDERED FOR UNINSURED PATIENTS THAT DO NOT QUALIFY FOR CHARITY CARE, REVENUE IS RECOGNIZED ON THE BASIS OF DISCOUNTED RATES IN ACCORDANCE WITH BHS' POLICY. PATIENT SERVICE REVENUES ARE REDUCED BY THE PROVISION FOR BAD DEBTS AND ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS. THESE AMOUNTS ARE BASED ON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS FOR EACH MAJOR PAYOR SOURCE, CONSIDERING BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN HEALTH CARE COVERAGE AND OTHER COLLECTION INDICATORS. MANAGEMENT REGULARLY REVIEWS COLLECTIONS DATA BY MAJOR PAYOR SOURCES IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS ON THE BASIS OF HISTORICAL EXPERIENCE, A SIGNIFICANT PORTION OF BHS' SELF-PAY PATIENTS WILL BE UNABLE OR UNWILLING TO PAY FOR THE SERVICES PROVIDED. THUS, BHS RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD SERVICES ARE PROVIDED RELATED TO SELF-PAY PATIENTS FOR RECEIVABLES ASSOCIATED WITH PATIENTS WHO HAVE THIRD-PARTY COVERAGE, BHS ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS AND A PROVISION FOR BAD DEBTS, IF NECESSARY ACCOUNTS RECEIVABLE ARE WRITTEN OFF AFTER COLLECTION EFFORTS HAVE BEEN FOLLOWED IN ACCORDANCE WITH BHS' POLICIES.</p>

Form and Line Reference	Explanation
Schedule H, Part III, Line 3, Bad Debt Expense Methodology	THE ENTIRE PROVISION FOR BAD DEBTS IS RECORDED AS A DEDUCTION FROM PATIENT SERVICE REVENUES. NONE OF THE PROVISION IS INCLUDED IN THE EXPENSES OF THE FORM 990 INCLUDING SCHEDULE H AND THE CALCULATION OF COMMUNITY BENEFIT.

Form and Line Reference	Explanation
Schedule H, Part III, Line 4, Bad debt expense - financial statement footnote	<p>BAPTIST HEALTH SYSTEM, INC AND SUBSIDIARIES NOTES TO CONSOLIDATED FINANCIAL STATEMENTS 2 SIGNIFICANT ACCOUNTING POLICIES NET PATIENT SERVICE REVENUES, ACCOUNTS RECEIVABLE, AND PROVISION FOR BAD DEBTS PATIENT SERVICE REVENUES ARE REPORTED AT ESTIMATED NET REALIZABLE AMOUNTS FOR SERVICES RENDERED THE ORGANIZATION RECOGNIZES PATIENT SERVICE REVENUES ASSOCIATED WITH PATIENTS WHO HAVE THIRD-PARTY PAYOR COVERAGE ON THE BASIS OF CONTRACTUAL RATES FOR THE SERVICES RENDERED FOR UNINSURED PATIENTS THAT DO NOT QUALIFY FOR CHARITY CARE, REVENUE IS RECOGNIZED ON THE BASIS OF DISCOUNTED RATES IN ACCORDANCE WITH THE ORGANIZATION'S POLICY PATIENT SERVICE REVENUES ARE REDUCED BY THE PROVISION FOR BAD DEBTS AND ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS THESE AMOUNTS ARE BASED ON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS FOR EACH MAJOR PAYOR SOURCE, CONSIDERING BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN HEALTHCARE COVERAGE AND OTHER COLLECTION INDICATORS MANAGEMENT REGULARLY REVIEWS COLLECTIONS DATA BY MAJOR PAYOR SOURCES IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS ON THE BASIS OF HISTORICAL EXPERIENCE, A SIGNIFICANT PORTION OF THE ORGANIZATION'S SELF-PAY PATIENTS WILL BE UNABLE OR UNWILLING TO PAY FOR THE SERVICES PROVIDED THUS, THE ORGANIZATION RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS IN THE PERIOD SERVICES ARE PROVIDED RELATED TO SELF-PAY PATIENTS FOR RECEIVABLES ASSOCIATED WITH PATIENTS WHO HAVE THIRD-PARTY COVERAGE, THE ORGANIZATION ANALYSES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS AND A PROVISION FOR BAD DEBTS, IF NECESSARY ACCOUNTS RECEIVABLE ARE WRITTEN OFF AFTER COLLECTION EFFORT HAS BEEN FOLLOWED IN ACCORDANCE WITH THE ORGANIZATION'S POLICIES 18832973</p>

Form and Line Reference	Explanation
Schedule H, Part III, Line 8, Community benefit & methodology for determining medicare costs	MEDICARE ALLOWABLE COSTS OF CARE BASED ON THE ORGANIZATION'S COST-TO-CHARGE RATIO AND COST ACCOUNTING SYSTEM ARE USED TO DETERMINE THE AMOUNT REPORTED ON LINE 6. NONE OF THE SHORTFALL REPORTED ON LINE 7 IS INCLUDED IN SCHEDULE H, PART I

Form and Line Reference	Explanation
Schedule H, Part III, Line 9b, Collection practices for patients eligible for financial assistance	YES, THE ORGANIZATION DOES HAVE A WRITTEN DEBT COLLECTION POLICY THE POLICY DOES NOT SPECIFICALLY ADDRESS THOSE PATIENTS WHO ARE KNOWN TO QUALIFY OR HAVE APPLIED FOR CHARITY CARE AS THE ORGANIZATION DOES NOT BILL THESE PATIENTS THE ORGANIZATION'S COST ACCOUNTING SYSTEM IDENTIFIES ALL PATIENTS WHO HAVE A PENDING OR APPROVED CHARITY APPLICATION THE ORGANIZATION WOULD ONLY BILL THE PATIENT IF, AFTER MULTIPLE ATTEMPTS TO OBTAIN ANY NEEDED DOCUMENTATION FROM THE PATIENT TO COMPLETE THE CHARITY APPROVAL PROCESS, THE PATIENT WAS NONCOMPLIANT

Form and Line Reference	Explanation
Schedule H, Part VI, Line 2, Needs assessment	BAPTIST HEALTH SYSTEM INC (BHS), PARENT COMPANY OF THE FILING ORGANIZATION, IS A MEMBER OF THE JACKSONVILLE COMMUNITY BENEFIT PARTNERSHIP THAT IS A COLLABORATIVE OF 5 HOSPITALS WHO WORK TOGETHER TO ACCESS AND ADDRESS IMPORTANT COMMUNITY HEALTH NEEDS. BAPTIST HEALTH HAS PARTNERED WITH 6 FAITH-BASED ORGANIZATIONS LOCATED IN VULNERABLE LOW-INCOME NEIGHBORHOODS IN NASSAU COUNTY WHERE A HEALTH NEEDS SURVEY IS CONDUCTED ANNUALLY. THE SURVEY OF THE MEMBERS OF OUR FAITH-BASED PARTNERS IS ANONYMOUS. IN ADDITION, DATA IS GATHERED FROM THE NORTHEAST FLORIDA COUNTS WEBSITE WHICH SERVES AS A SOURCE OF POPULATION DATA AND INFORMATION ABOUT THE HEALTH STATUS OF THE COMMUNITY. IT GATHERS INFORMATION FOR BAKER, CLAY, DUVAL, FLAGLER, NASSAU, ST. JOHNS, AND VOLUSIA COUNTIES.

Form and Line Reference	Explanation
Schedule H, Part VI, Line 3, Patient education of eligibility for assistance	AT EVERY PATIENT ACCESS POINT, "GUIDELINES FOR CHARITY CARE ELIGIBILITY" CARDS ARE PROVIDED THAT CONTAINS FINANCIAL DISCOUNT AND CHARITY CARE INFORMATION THIS INCLUDES A GENERAL CHART OF ELIGIBLE INCOME LEVELS AND ENCOURAGES PATIENTS TO SPEAK WITH ONE OF OUR PATIENT FINANCIAL ADVOCATES TO ARRANGE A FINANCIAL EVALUATION THE ORGANIZATION SENDS STATEMENTS TO PATIENTS WHO HAVE APPLIED FOR CHARITY CARE BUT HAVE NOT PROVIDED ALL THE DOCUMENTATION THAT IS REQUIRED TO MAKE A DETERMINATION, LETTERS ARE SENT BY THE ORGANIZATION REQUESTING THE INFORMATION TO COMPLETE THEIR APPLICATION

Form and Line Reference	Explanation
Schedule H, Part VI, Line 4, Community information	<p>BAPTIST MEDICAL CENTER OF NASSAU NASSAU COUNTY NASSAU COUNTY HAS A TOTAL AREA OF 725.86 SQUARE MILES, OF WHICH 651.55 SQUARE MILES (OR 89.76%) IS LAND AND 74.30 SQUARE MILES (OR 10.24%) IS WATER, MUCH OF IT IN THE ATLANTIC OCEAN FERNANDINA BEACH IS LOCATED ON AMELIA ISLAND, THE COUNTY'S ONE INHABITED ISLAND THERE ARE 75,710 PEOPLE RESIDING IN NASSAU THE COUNTY THE RACIAL MAKEUP OF THE COUNTY IS 90.02% WHITE, 7.74% BLACK OR AFRICAN AMERICAN, 0.43% NATIVE AMERICAN, 0.46% ASIAN, 0.03% PACIFIC ISLANDER, 0.32% FROM OTHER RACES, AND 1.00% FROM TWO OR MORE RACES 1.51% OF THE POPULATION ARE HISPANIC OR LATINO OF ANY RACE IN THE COUNTY THE POPULATION IS SPREAD OUT WITH 25.00% UNDER THE AGE OF 18, 7.20% FROM 18 TO 24, 28.80% FROM 25 TO 44, 26.30% FROM 45 TO 64, AND 12.60% WHO ARE 65 YEARS OF AGE OR OLDER THE MEDIAN AGE IS 38 YEARS THE MEDIAN INCOME FOR A HOUSEHOLD IN THE COUNTY IS \$46,022, AND THE MEDIAN INCOME FOR A FAMILY WAS \$52,477 MALES HAD A MEDIAN INCOME OF \$37,027 VERSUS \$25,443 FOR FEMALES THE PER CAPITA INCOME FOR THE COUNTY IS \$22,836 ABOUT 6.40% OF FAMILIES AND 9.10% OF THE POPULATION IS BELOW THE POVERTY LINE, INCLUDING 10.90% OF THOSE UNDER AGE 18 AND 8.90% OF THOSE AGE 65 OR OVER</p>

Form and Line Reference	Explanation
Schedule H, Part VI, Line 5, Promotion of community health	BAPTIST HEALTH SYSTEM INC (BHS), PARENT COMPANY OF THE FILING ORGANIZATION, CONTINUES TO MAINTAIN AN OPEN MEDICAL STAFF A DESIGNATED SOCIAL RESPONSIBILITY COMMUNITY HEALTH BOARD COMMITTEE CONSISTING OF NORTHEAST FLORIDA RESIDENTS WHO ALSO SERVE ON BAPTIST HOSPITAL BOARDS OF DIRECTORS PROVIDES DIRECTION TO THE COMMUNITY HEALTH WORK BASED ON THE COMMUNITY NEED WITHIN THE FOUR COUNTY AREA SERVED BY BAPTIST HEALTH BAPTIST HEALTH CONTINUES TO DONATE MORE THAN \$1 6 MILLION TO SUPPORT NONPROFIT ORGANIZATIONS THAT PROVIDE HEALTH SERVICES TO THE UNDERSERVED AND LOW INCOME COMMUNITY SOME OF THE NONPROFIT ORGANIZATIONS PROVIDE PRIMARY CARE FOR THE UNINSURED AND THE UNDERINSURED SOME PROVIDE BEHAVIORAL HEALTH SERVICES TO FAMILIES WHO WOULD NOT OTHERWISE HAVE ACCESS WHILE OTHERS PROVIDE HEALTH SERVICES AND TRANSPORTATION FOR THE FRAIL ELDERLY

Form and Line Reference	Explanation
Schedule H, Part VI, Line 6, Affiliated health care system	BAPTIST HEALTH SYSTEM, INC (BHS) IS THE PARENT AFFILIATE OF BAPTIST MEDICAL CENTER OF NASSAU, INC (BMCN) THE SOCIAL RESPONSIBILITY AND COMMUNITY HEALTH TEAM AT BHS COORDINATES THE FUNDING OF NONPROFIT PARTNERS FOR BMCN AND WORKS WITH OUR EMPLOYEES IN FACILITATING VOLUNTEER OPPORTUNITIES ACROSS OUR COMMUNITY. MEMBERS OF THE BMCN BOARD OF DIRECTORS ALSO SERVE ON THE SOCIAL RESPONSIBILITY AND COMMUNITY HEALTH COMMITTEE. BMCN WORKS CLOSELY WITH A NUMBER OF NONPROFIT PARTNERS TO MEET THE COMMUNITY HEALTH NEEDS OF NASSAU COUNTY, FLORIDA

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 7, STATE FILING OF COMMUNITY BENEFIT REPORT	BAPTIST HEALTH SYSTEM, INC (BHS), PARENT COMPANY OF THE FILING ORGANIZATION, IS LOCATED WITHIN THE NORTHEAST FLORIDA QUADRANT THERE ARE NO REQUIREMENTS FOR STATE FILING IN FLORIDA OF THE ANNUAL COMMUNITY BENEFIT REPORT HOWEVER, BHS DOES PUBLISH THE REPORT AND IT IS AVAILABLE UPON REQUEST OR AT THE WWW.BAPTISTJAX.COM WEBSITE

Additional Data

Software ID: 13000248
Software Version: 2013v3.1
EIN: 59-3234721
Name: BAPTIST MEDICAL CENTER OF NASSAU INC

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
Schedule H, Part V Sec B, Line 3, Community Served by Needs Assessment	(1) - BAPTIST MEDICAL CENTER OF NASSAU, INC NINE HOSPITALS (BAPTIST MEDICAL CENTER, BAPTIST MEDICAL CENTER SOUTH, WOLFSON CHILDREN'S HOSPITAL, BAPTIST MEDICAL CENTER OF THE BEACHES, INC , BAPTIST MEDICAL CENTER OF NASSAU, INC , MAYO CLINIC, ST VINCENT'S MEDICAL CENTER RIVERSIDE, ST VINCENT'S MEDICAL CENTER SOUTH AND UF HEALTH) AND FOUR DEPARTMENTS OF HEALTH (FLORIDA DEPARTMENTS' OF HEALTH FOR CLAY COUNTY, DUVAL COUNTY, ST JOHN'S COUNTY AND NASSAU COUNTY) CONVENED WITH THE HEALTH PLANNING COUNCIL OF NORTHEAST FLORIDA TO FACILITATE THE CHNA EACH HOSPITAL AGREED ON ITS RESPECTIVE TARGETED COMMUNITIES INTERNAL HOSPITAL CENSUS, EXISTING COMMUNITY BENEFIT PROGRAMS, AS WELL AS SECONDARY DATA COLLECTION WERE USED A COMMUNITY HEALTH SURVEY WAS DEVELOPED AND ADMINISTERED TO A BROAD, VARIED RANGE OF RESIDENTS LIVING IN THE TARGETED FIVE-COUNTY COMMUNITY THE SURVEY CONTAINED QUESTIONS REGARDING PERCEIVED QUALITY OF LIFE AND HEALTH OF THE COMMUNITY, BARRIERS TO HEALTH CARE, USE OF HEALTH CARE NEEDS AND DEMOGRAPHIC INFORMATION THE SURVEY INCLUDED PARTICIPANTS FORM CLAY, DUVAL, NASSAU AND ST JOHNS COUNTIES THE INTERNET PANEL METHOD WAS USED IN ORDER TO REACH THE LARGEST POSSIBLE NUMBER OF QUALIFIED RESPONDENTS FOCUS GROUPS AND ROUND TABLE DISCUSSIONS WERE ANOTHER METHOD USED TO TAKE INTO ACCOUNT INPUT FROM THE PERSONS WHO REPRESENT THE BROAD INTEREST OF COMMUNITY SERVED THE ROUNDTABLE DISCUSSIONS ALLOWED FOR THE IDENTIFICATION OF THE NEEDS AND PRIORITIES OF PARTICIPANTS WHO HAVE THE KNOWLEDGE AND EXPERTISE TO INFORM THE RESEARCH REPRESENTATIVES FROM CLAY, DUVAL, NASSAU, PUTNAM AND ST JOHNS COUNTIES GAVE THEIR INPUT ON MULTIPLE DIMENSIONS OF THEIR COMMUNITIES, INCLUDING THE BUILT ENVIRONMENT, LOCAL ECONOMY, BARRIERS TO ACCESS AND MOTIVATION FOR HEALTHY LIVING FOR THE SECONDARY RESEARCH, PUBLIC HEALTH RELATED DATA WAS GATHERED FROM FIVE COUNTIES EACH COUNTY HEALTH DEPARTMENT PROVIDED AN ASSESSMENT THAT DETERMINED PUBLIC HEALTH PRIORITIES FOR THE NEXT THREE TO FIVE YEARS THE PARTNERSHIP'S CHNA REFLECTS THE PRIORITIES IDENTIFIED IN THE HEALTH DEPARTMENT ASSESSMENTS AND ITS CORRESPONDING HEALTH IMPROVEMENT PLAN ,

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6l, 7, 10, 11, 12l, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
Schedule H, Part V Sec B, Line 4, Other Hospital Facilities included in Needs Assessment	(1) - BAPTIST MEDICAL CENTER OF NASSAU, INC THE HOSPITALS INVOLVED IN THE CHNA WERE BAPTIST MEDICAL CENTER - DUVAL COUNTY, BAPTIST MEDICAL CENTER BEACHES - DUVAL COUNTY, BAPTIST MEDICAL CENTER - NASSAU COUNTY, BAPTIST MEDICAL CENTER SOUTH - DUVAL COUNTY AND NORTHERN ST JOHNS COUNTY, BROOKS REHABILITATION -DUVAL COUNTY AND ST JOHNS COUNTY, MAYO CLINIC - DUVAL COUNTY, ST VINCENT'S MEDICAL CENTER RIVERSIDE - DUVAL COUNTY, CLAY COUNTY AND PUTNAM COUNTY, ST VINCENT'S MEDICAL CENTER SOUTHSIDE - DUVAL COUNTY, SHANDS JACKSONVILLE MEDICAL CENTER - DUVAL COUNTY, AND WOLFSON CHILDREN'S HOSPITAL - DUVAL COUNTY ,

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
Schedule H, Part V Sec B, Line 7, Needs not addressed in Needs Assessment	(1) - BAPTIST MEDICAL CENTER OF NASSAU, INC BAPTIST MEDICAL CENTER OF NASSAU'S (BMCN) SELECTED PRIORITIES ARE HEART DISEASE, STROKE, DIABETES, NUTRITION, MAMMOGRAM, SMOKING CESSATION, AND ACCESS TO FOOD AND PHYSICAL ACTIVITY BMCN HAS CHOSEN NOT TO ACTIVELY ADDRESS THE REMAINING HEALTH NEEDS IDENTIFIED IN THE CHNA AS THEY WERE NOT SELECTED AS PRIORITY HEALTH NEEDS TAKING EXISTING COMMUNITY RESOURCES INTO CONSIDERATION AND THAT SOME PRIORITIES ARE BEING ADDRESSED BY OTHER HOSPITALS OR ORGANIZATIONS, BMCN HAS SELECTED TO CONCENTRATE ONLY ON THOSE HEALTH NEEDS THAT WE CAN MOST EFFECTIVELY ADDRESS GIVEN OUR AREAS OF FOCUS AND EXPERTISE THE PRIORITIES IDENTIFIED IN THE CHNA THAT WERE NOT ADDRESSED WERE (1) CLEAN AND HEALTHY ENVIRONMENT AIR AND WATER QUALITY, ADULT ASTHMA, RESPIRATORY ILLNESS, AND (2) COMMUNICABLE DISEASES SEXUALLY TRANSMITTED DISEASES, (STDS), INCLUDING HIV, INFLUENZA AND PNEUMONIA, HEPATITIS AND HOUSING ,

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
Schedule H, Part V Sec B, Line 18e, Efforts made before initiating collection actions	(1) - BAPTIST MEDICAL CENTER OF NASSAU, INC AT EVERY PATIENT ACCESS POINT, "GUIDELINES FOR CHARITY CARE ELIGIBILITY" CARDS ARE PROVIDED THAT CONTAINS FINANCIAL DISCOUNT AND CHARITY CARE INFORMATION THIS INCLUDES A GENERAL CHART OF ELIGIBLE INCOME LEVELS AND ENCOURAGES PATIENTS TO SPEAK WITH OUR PATIENT FINANCIAL ADVOCATES TO ARRANGE A FINANCIAL EVALUATION IF SEEN BY ONE OF THE ORGANIZATION'S PATIENT FINANCIAL ADVOCATES, THE PATIENT IS ADVISED PRIOR TO DISCHARGE ALL STATEMENTS TO PATIENTS PROVIDE A NUMBER TO CALL IF THEY NEED FINANCIAL ASSISTANCE ALL APPLICATIONS FOR FINANCIAL ASSISTANCE ARE MAINTAINED WHETHER OR NOT THE PATIENT QUALIFIES ,

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
Schedule H, Part V Sec B, Line 20d, How amounts charged to FAP-eligible patients were determined	(1) - BAPTIST MEDICAL CENTER OF NASSAU, INC THE ORGANIZATION HAS AN AUTOMATIC 40% DISCOUNT FOR ALL UNINSURED PATIENTS ,

**Schedule I
(Form 990)**

OMB No 1545-0047

**Grants and Other Assistance to Organizations,
Governments and Individuals in the United States**

Complete if the organization answered "Yes," to Form 990, Part IV, line 21 or 22.

► Attach to Form 990

► Information about Schedule I (Form 990) and its instructions is at www.irs.gov/form990.**2013****Open to Public
Inspection**Department of the Treasury
Internal Revenue Service

Name of the organization

BAPTIST MEDICAL CENTER OF NASSAU INC

Employer identification number

59-3234721

Part I General Information on Grants and Assistance

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? Yes No
- 2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

Part II Grants and Other Assistance to Governments and Organizations in the United States. Complete if the organization answered "Yes" to Form 990, Part IV, line 21, for any recipient that received more than \$5,000. Part II can be duplicated if additional space is needed.

(a) Name and address of organization or government	(b) EIN	(c) IRC Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
(1) BOYS AND GIRLS CLUB OF NASSAU COUNTY FOUNDATION INC PO BOX 16003 FERNANDINA BEACH, FL 32035	59-3672345	501(C)(3)	15,000				SUPPORT FOR YOUTH TO IMPROVE THEIR LIVES IN THE NASSAU COUNTY COMMUNITY
(2) NASSAU COUNTY ECONOMIC DEVELOPMENT BOARD INC 76346 WILLIAM BURGESS BLVD YULEE, FL 32097		N/A	10,350				DONATION TO NASSAU COUNTY GOVERNMENT AGENCY FOR JOB CREATION AND ECONOMIC GROWTH

- 2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table ► 2
- 3 Enter total number of other organizations listed in the line 1 table ► 0

Part III Grants and Other Assistance to Individuals in the United States. Complete if the organization answered "Yes" to Form 990, Part IV, line 22.
 Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance

Part IV Supplemental Information. Provide the information required in Part I, line 2, Part III, column (b), and any other additional information.

Return Reference	Explanation
Schedule I, Part I, Line 2, Procedures for monitoring use of grant funds	ANNUAL BUDGETS FOR COMMUNITY DONATIONS ARE PREPARED BY THE HOSPITAL ORGANIZATION AND APPROVED BY BAPTIST HEALTH SYSTEM, INC , PARENT AFFILIATE OF THE ORGANIZATION
Schedule I, Part II, Column H, Purpose of grant or assistance	NASSAU COUNTY ECONOMIC DEVELOPMENT BOARD, INC , N/A DONATION TO NASSAU COUNTY GOVERNMENT AGENCY FOR JOB CREATION AND ECONOMIC GROWTH ,

Schedule J
(Form 990)**Compensation Information**

OMB No 1545-0047

2013**Open to Public
Inspection**Department of the Treasury
Internal Revenue ServiceFor certain Officers, Directors, Trustees, Key Employees, and Highest
Compensated Employees► Complete if the organization answered "Yes" to Form 990, Part IV, line 23.
► Attach to Form 990. ► See separate instructions.► Information about Schedule J (Form 990) and its instructions is at www.irs.gov/form990.Name of the organization
BAPTIST MEDICAL CENTER OF NASSAU INC

Employer identification number

59-3234721

Part I Questions Regarding Compensation**1a** Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items

- | | |
|--|--|
| <input type="checkbox"/> First-class or charter travel | <input type="checkbox"/> Housing allowance or residence for personal use |
| <input type="checkbox"/> Travel for companions | <input type="checkbox"/> Payments for business use of personal residence |
| <input type="checkbox"/> Tax indemnification and gross-up payments | <input type="checkbox"/> Health or social club dues or initiation fees |
| <input type="checkbox"/> Discretionary spending account | <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef) |

b If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain**2** Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?**3** Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III

- | | |
|--|--|
| <input type="checkbox"/> Compensation committee | <input type="checkbox"/> Written employment contract |
| <input type="checkbox"/> Independent compensation consultant | <input type="checkbox"/> Compensation survey or study |
| <input type="checkbox"/> Form 990 of other organizations | <input type="checkbox"/> Approval by the board or compensation committee |

4 During the year, did any person listed in Form 990, Part VII, Section A, line 1a with respect to the filing organization or a related organization**a** Receive a severance payment or change-of-control payment?**b** Participate in, or receive payment from, a supplemental nonqualified retirement plan?**c** Participate in, or receive payment from, an equity-based compensation arrangement?

If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III

Only 501(c)(3) and 501(c)(4) organizations only must complete lines 5-9.**5** For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of**a** The organization?**b** Any related organization?

If "Yes," to line 5a or 5b, describe in Part III

6 For persons listed in Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of**a** The organization?**b** Any related organization?

If "Yes," to line 6a or 6b, describe in Part III

7 For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III**8** Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III**9** If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

	Yes	No
1b		
2		
4a		No
4b	Yes	
4c		No
5a		No
5b		No
6a		No
6b	Yes	
7		No
8		No
9		

Part II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees. Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported in Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that are not listed on Form 990, Part VII.

Note. The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported as deferred in prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) A HUGH GREENE PRESIDENT & DIRECTOR	(i) 0 (ii) 752,886	(i) 0 (ii) 290,000	(i) 0 (ii) 30,000	(i) 0 (ii) 499,028	(i) 0 (ii) 15,863	(i) 0 (ii) 1,587,777	(i) 0 (ii) 0
(2) HARVEY GRANGER ASSISTANT SECRETARY	(i) 0 (ii) 366,616	(i) 0 (ii) 105,000	(i) 0 (ii) 15,000	(i) 0 (ii) 196,051	(i) 0 (ii) 19,231	(i) 0 (ii) 701,898	(i) 0 (ii) 0
(3) STEPHEN LEE VICE PRESIDENT	(i) 191,897 (ii) 0	(i) 58,979 (ii) 0	(i) 10,000 (ii) 0	(i) 35,618 (ii) 0	(i) 11,357 (ii) 0	(i) 307,851 (ii) 0	(i) 0 (ii) 0
(4) JOHN F WILBANKS EXECUTIVE VP	(i) 0 (ii) 462,492	(i) 0 (ii) 157,500	(i) 0 (ii) 15,000	(i) 0 (ii) 228,752	(i) 0 (ii) 12,580	(i) 0 (ii) 876,324	(i) 0 (ii) 0
(5) MICHAEL LUKASZEWSKI SVP/CFO	(i) 0 (ii) 395,982	(i) 0 (ii) 280,707	(i) 0 (ii) 15,000	(i) 0 (ii) 4,462	(i) 0 (ii) 15,774	(i) 0 (ii) 711,925	(i) 0 (ii) 0
(6) BARBARA GINGHER ASSISTANT ADMINISTRATOR, NURSING	(i) 128,433 (ii) 0	(i) 15,500 (ii) 0	(i) 10,000 (ii) 0	(i) 23,749 (ii) 0	(i) 6,760 (ii) 0	(i) 184,442 (ii) 0	(i) 0 (ii) 0
(7) STEPHEN BEAN PHARMACIST	(i) 134,718 (ii) 0	(i) 138 (ii) 0	(i) 0 (ii) 0	(i) 19,368 (ii) 0	(i) 13,892 (ii) 0	(i) 168,116 (ii) 0	(i) 0 (ii) 0

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II
Also complete this part for any additional information

Return Reference	Explanation
Schedule J, Part I, Line 3, Arrangement used to establish the top management official's compensation	IN ACCORDANCE WITH THE EXECUTIVE COMPENSATION POLICY OF BAPTIST HEALTH SYSTEM, INC (BHS), THE ORGANIZATION'S SOLE MEMBER, BHS'S COMPENSATION COMMITTEE (MADE UP OF INDEPENDENT DIRECTORS OF BHS) ENGAGES ANNUALLY A THIRD PARTY COMPENSATION CONSULTANT WHO PROVIDES A DATABASE COMPOSED OF CURRENT DATA REGARDING COMPENSATION PAID FOR EACH EXECUTIVE POSITION BY SIMILARLY SITUATED TAX EXEMPT HEALTH SYSTEMS IN THE COUNTRY THESE HEALTH SYSTEMS ARE GENERALLY THE SAME SIZE AS BHS, CONSIDERING REVENUE AND OTHER APPROPRIATE INDICATORS THE GROUP OF COMPARATOR COMPANIES THAT IS DERIVED BASED ON THE ABOVE STATED PARAMETERS COMPRIZE THE "MARKET" WHEN THE COMMITTEE MEETS WITH SUCH CONSULTANT, THE CONSULTANT PROVIDES TO COMMITTEE MEMBERS COMPENSATION TARGET LEVELS THAT ARE COMPETITIVE WITH THE MARKET GENERALLY, THE MEDIAN OF THE MARKET IS TARGETED THE ACTUAL AMOUNT THAT HEALTH SYSTEM EXECUTIVES RECEIVE AS COMPENSATION MAY BE HIGHER OR LOWER THAN THE MEDIAN, DEPENDING ON THE HEALTH SYSTEM AND THE INDIVIDUAL'S PERFORMANCE THE OBJECTIVE IS TO HAVE A STRONG LINK BETWEEN HEALTH SYSTEM AND INDIVIDUAL PERFORMANCE AND EXECUTIVE COMPENSATION SUCH THAT IF THE HEALTH SYSTEM AND THE INDIVIDUAL PERFORM AT AN OPTIMAL LEVEL, HIS OR HER COMPENSATION IS IN THE HIGHER RANGE OF THE MARKET CONVERSELY, IF EITHER THE HEALTH SYSTEM OR INDIVIDUAL PERFORMANCE IS BELOW EXPECTATION, COMPENSATION MAY BE IN THE LOWER RANGE OF THE MARKET THE MINUTES OF THE ANNUAL COMPENSATION COMMITTEE ARE RECORDED BY THE COMMITTEE'S COMPENSATION CONSULTANT AND ARE APPROVED PROMPTLY BY THE CHAIR OF SUCH COMMITTEE
Schedule J, Part I, Line 4b, Supplemental nonqualified retirement plan	BAPTIST HEALTH SYSTEM, INC (BHS), PARENT AFFILIATE OF BAPTIST MEDICAL CENTER OF NASSAU, INC (BMCN), HAS TWO ACTIVE SUPPLEMENTAL NONQUALIFIED RETIREMENT PLANS (SERPS) ONE IS FOR CERTAIN EXECUTIVES (SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN) AND THE OTHER IS FOR CERTAIN VICE PRESIDENTS (VICE-PRESIDENT SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN) THESE SERPS ARE PLANS DESCRIBED IN IRS SECTION 457(F) THE BENEFITS UNDER THESE PLANS ACCRUE DURING EACH EXECUTIVE'S TERM OF EMPLOYMENT THESE BENEFITS ARE UNVESTED AND SUBJECT TO FORFEITURE UNTIL THE COVERED EMPLOYEE REACHES RETIREMENT AGE THE FOLLOWING INDIVIDUALS ACCRUED UNVESTED BENEFITS UNDER THESE PLANS DURING CALENDAR YEAR 2013 A HUGH GREENE, \$459,770, JOHN F WILBANKS, \$192,103, AND HARVEY GRANGER, \$158,310 THESE AMOUNTS ARE INCLUDED IN SCHEDULE J, PART II, COLUMN (C) FOR EACH OF THE LISTED INDIVIDUALS
Schedule J, Part I, Line 6b, Compensation contingent on net earnings of a related organization	BAPTIST HEALTH SYSTEM, INC, PARENT COMPANY OF THE FILING ORGANIZATION, POLICY PROVIDES FOR ANNUAL REVIEWS OF ALL EMPLOYEES AN EMPLOYEE'S PERFORMANCE INCLUDES AN EVALUATION BY THE EMPLOYEE AND SUPERVISOR IN MEETING INDIVIDUAL AND ORGANIZATIONAL GOALS BASED ON AN EMPLOYEE'S PERFORMANCE IN MEETING THESE GOALS AND THE OPERATING MARGIN OF THE CONSOLIDATED HEALTH SYSTEM FOR THE FISCAL YEAR, A BONUS MAY BE PAID TO EMPLOYEES AT THE MANAGERIAL LEVEL AND ABOVE, INCLUDING THOSE LISTED IN SCHEDULE J, AND IS INCLUDED IN THE EMPLOYEE'S W-2 REPORTABLE COMPENSATION

**Schedule K
(Form 990)****Supplemental Information on Tax Exempt Bonds****2013****Open to Public
Inspection**Department of the Treasury
Internal Revenue Service

► Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
 ► Attach to Form 990. ► See separate instructions.
 ► Information about Schedule K (Form 990) and its instructions is at www.irs.gov/form990.

Name of the organization

BAPTIST MEDICAL CENTER OF NASSAU INC

Employer identification number

59-3234721

Part I Bond Issues

(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
						Yes	No	Yes	No	Yes	No
A JACKSONVILLE HEALTH FACILITIES AUTHORITY VARIABLE RATE HOSPITAL REVENUE REFUNDING EXTENDABLE NOTES SERIES 2007CDE			12-01-2011	3,264,000	REFUND SERIES 2007CDE BONDS		X		X		X

Part II Proceeds

1	Amount of bonds retired	A		B		C		D		
		1,050,000		0		3,264,000		0		
2	Amount of bonds legally defeased			0						
3	Total proceeds of issue			3,264,000						
4	Gross proceeds in reserve funds			0						
5	Capitalized interest from proceeds			0						
6	Proceeds in refunding escrows			3,255,494						
7	Issuance costs from proceeds			8,506						
8	Credit enhancement from proceeds			0						
9	Working capital expenditures from proceeds			0						
10	Capital expenditures from proceeds			0						
11	Other spent proceeds			0						
12	Other unspent proceeds			0						
13	Year of substantial completion			2007						
14	Were the bonds issued as part of a current refunding issue?	Yes	No		Yes	No	Yes	No	Yes	No
15	Were the bonds issued as part of an advance refunding issue?		X							
16	Has the final allocation of proceeds been made?	X								
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X								

Part III Private Business Use

1	Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?	A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
2	Are there any lease arrangements that may result in private business use of bond-financed property?		X						

Part III Private Business Use (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?		X						
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c Are there any research agreements that may result in private business use of bond-financed property?		X						
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ►			0 %					
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ►			0 %					
6 Total of lines 4 and 5			0 %					
7 Does the bond issue meet the private security or payment test?	X							
8a Has there been a sale or disposition of any of the bond financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?		X						
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of								
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1 141-12 and 1 145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1 141-12 and 1 145-2?								

Part IV Arbitrage

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has the issuer filed Form 8038-T?		X						
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?		X						
b Exception to rebate?		X						
c No rebate due?		X						
If you checked "No rebate due" in line 2c, provide in Part VI the date the rebate computation was performed								
3 Is the bond issue a variable rate issue?	X							
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?	X							
b Name of provider	UBS AND WELLS FARGO							
c Term of hedge	16 1							
d Was the hedge superintegrated?		X						
e Was the hedge terminated?		X						

Part IV Arbitrage (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
5a Were gross proceeds invested in a guaranteed investment contract (GIC)?		X						
b Name of provider								
c Term of GIC		0 0						
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6 Were any gross proceeds invested beyond an available temporary period?		X						
7 Has the organization established written procedures to monitor the requirements of section 148?	X							

Part V Procedures To Undertake Corrective Action

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations?		X						

Part VI Supplemental Information. Provide additional information for responses to questions on Schedule K (see instructions).

Return Reference	Explanation
SCHEDULE K, PART I, COLUMN (C), SERIES 2007 CDE	CUSIP #'S 2007C N/A 2007D 469404UP0 2007E 469404UM7

Schedule L

Transactions with Interested Persons

OMB No 1545-0047

2013

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

► Complete if the organization answered "Yes" on Form 990, Part IV, lines 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.

- Attach to Form 990 or Form 990-EZ. ► See separate instructions.
- Information about Schedule L (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

Name of the organization
BAPTIST MEDICAL CENTER OF NASSAU INC

Employer identification number

59-3234721

Part I Excess Benefit Transactions (section 501(c)(3) and section 501(c)(4) organizations only)

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1	(a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction		(d) Corrected?	
			Yes	No		

2 Enter the amount of tax incurred by organization managers or disqualified persons during the year under section 4958 \$

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization ► \$

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a, or Form 990, Part IV, line 26, or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

Part III Grants or Assistance Benefitting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

Part IV Business Transactions Involving Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) GREGORY SMITH MD	DIRECTOR OF FILING ORGANIZATION AND OFFICER OF AMELIA ISLAND ORTHOPAEDICS	178,826	ORTHOPAEDIC SURGICAL SERVICES TO EMERGENCY DEPT , \$136,000, LEASE PAYMENTS TO FILING ORGANIZATION, \$42,826		No
(2) GERALD BURFORD MD	DIRECTOR OF FILING ORGANIZATION AND OFFICER OF AMELIA INTERNAL MEDICINE	108,282	LEASE PAYMENTS TO FILING ORGANIZATION		No

Part V Supplemental Information

Provide additional information for responses to questions on Schedule L (see instructions)

Return Reference

Explanation

2013

Open to Public
Inspection**SCHEDULE O**
(Form 990 or 990-EZ)Department of the Treasury
Internal Revenue Service**Supplemental Information to Form 990 or 990-EZ**Complete to provide information for responses to specific questions on
Form 990 or to provide any additional information.

► Attach to Form 990 or 990-EZ.

► Information about Schedule O (Form 990 or 990-EZ) and its instructions is at
www.irs.gov/form990.Name of the organization
BAPTIST MEDICAL CENTER OF NASSAU INC

Employer identification number

59-3234721

990 Schedule O, Supplemental Information

Return Reference	Explanation
Form 990, Part VI, Sec A, Line 6, Classes of members or stockholders	THE ORGANIZATION HAS A SOLE CORPORATE MEMBER, BAPTIST HEALTH SYSTEM, INC
Form 990, Part VI, Sec A, Line 7a, Members or stockholders electing members of governing body	THE BOARD OF DIRECTORS OF BAPTIST HEALTH SYSTEM, INC, THE SOLE CORPORATE MEMBER OF THE ORGANIZATION, ELECTS THE MEMBERS OF THE GOVERNING BODY OF THE ORGANIZATION
Form 990, Part VI, Sec A, Line 7b, Decisions requiring approval by members or stockholders	THE BOARD OF DIRECTORS OF BAPTIST HEALTH SYSTEM, INC, THE SOLE CORPORATE MEMBER OF THE ORGANIZATION, HAS THE RIGHT TO REMOVE DIRECTORS OF THE ORGANIZATION AND MUST APPROVE ANY AMENDMENTS TO THE GOVERNING DOCUMENTS OF THE ORGANIZATION
Form 990, Part VI, Sec B, Line 11b, Review of form 990 by governing body	WHILE THE ORGANIZATION'S GOVERNING BODY DID NOT REVIEW THE FORM 990, THE BOARD OF DIRECTORS OF BAPTIST HEALTH SYSTEM, INC, THE SOLE CORPORATE MEMBER OF THE ORGANIZATION, WAS PROVIDED THE ORGANIZATION'S ENTIRE FORM 990 PRIOR TO ITS FILING VIA A LINK TO A PASSWORD-PROTECTED WEBSITE
Form 990, Part VI, Sec B, Line 12c, Conflict of interest policy	THE BOARD OF DIRECTORS OF THE ORGANIZATION'S SOLE MEMBER, BAPTIST HEALTH SYSTEM, INC, HAS APPOINTED A CONFLICTS OF INTEREST COMMITTEE WHICH REGULARLY REVIEWS THE REQUIRED DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST BY THE DIRECTORS AND OFFICERS OF THE ORGANIZATION AND ITS AFFILIATES AND RECOMMENDS ANY ACTION TO BE TAKEN WITH REGARD TO SUCH DISCLOSURES IN ACCORDANCE WITH THE CONFLICTS OF INTEREST POLICY, DURING MEETINGS OF THE ORGANIZATION'S GOVERNING BODY, A DIRECTOR WHO MAY HAVE A CONFLICT OF INTEREST IS EXCUSED FROM DISCUSSION BY THE GOVERNING BODY ABOUT ANY TRANSACTION OR MATTER THAT MAY HAVE GIVEN RISE TO THE DIRECTOR'S ACTUAL OR POTENTIAL CONFLICT OF INTEREST
Form 990, Part VI, Sec B, Line 15a, Process to establish compensation of top management official	IN ACCORDANCE WITH THE EXECUTIVE COMPENSATION POLICY OF BAPTIST HEALTH SYSTEM, INC (BHS), THE ORGANIZATION'S SOLE MEMBER, BHS'S COMPENSATION COMMITTEE (MADE UP OF INDEPENDENT DIRECTORS OF BHS) ENGAGES ANNUALLY A THIRD PARTY COMPENSATION CONSULTANT WHO PROVIDES A DATABASE COMPOSED OF CURRENT DATA REGARDING COMPENSATION PAID FOR EACH EXECUTIVE POSITION BY SIMILARLY SITUATED TAX EXEMPT HEALTH SYSTEMS IN THE COUNTRY. THESE HEALTH SYSTEMS ARE GENERALLY THE SAME SIZE AS BHS, CONSIDERING REVENUE AND OTHER APPROPRIATE INDICATORS. THE GROUP OF COMPARATOR COMPANIES THAT IS DERIVED BASED ON THE ABOVE STATED PARAMETERS COMprise THE "MARKET". WHEN THE COMMITTEE MEETS WITH SUCH CONSULTANT, THE CONSULTANT PROVIDES TO COMMITTEE MEMBERS COMPENSATION TARGET LEVELS THAT ARE COMPETITIVE WITH THE MARKET. GENERALLY, THE MEDIAN OF THE MARKET IS TARGETED. THE ACTUAL AMOUNT THAT HEALTH SYSTEM EXECUTIVES RECEIVE AS COMPENSATION MAY BE HIGHER OR LOWER THAN THE MEDIAN, DEPENDING ON THE HEALTH SYSTEM'S AND THE INDIVIDUAL'S PERFORMANCE. THE OBJECTIVE IS TO HAVE A STRONG LINK BETWEEN HEALTH SYSTEM AND INDIVIDUAL PERFORMANCE AND EXECUTIVE COMPENSATION SUCH THAT IF THE HEALTH SYSTEM AND THE INDIVIDUAL PERFORM AT AN OPTIMAL LEVEL, HIS OR HER COMPENSATION IS IN THE HIGHER RANGE OF THE MARKET. CONVERSELY, IF EITHER THE HEALTH SYSTEM OR INDIVIDUAL PERFORMANCE IS BELOW EXPECTATION, COMPENSATION MAY BE IN THE LOWER RANGE OF THE MARKET. THE MINUTES OF THE ANNUAL COMPENSATION COMMITTEE ARE RECORDED BY THE COMMITTEE'S COMPENSATION CONSULTANT AND ARE APPROVED PROMPTLY BY THE CHAIR OF SUCH COMMITTEE
Form 990, Part VI, Sec B, Line 15b, Process to establish compensation of other employees	ALL OFFICERS AND KEY EMPLOYEES OF THE ORGANIZATION WERE INCLUDED IN THE EXECUTIVE COMPENSATION POLICY DESCRIBED ON FORM 990, PART VI, LINE 15A. THIS PROCESS IS USED TO ESTABLISH COMPENSATION FOR THESE INDIVIDUALS FOR EACH CALENDAR YEAR
Form 990, Part VI, Sec C, Line 19, Required documents available to the public	UPON RECEIVING A REQUEST FROM ANYONE, THE ORGANIZATION WILL SUPPLY A COPY OF ITS GOVERNING DOCUMENTS, CONFLICTS OF INTEREST POLICY, FINANCIAL STATEMENTS AND ITS MOST RECENTLY FILED FORM 990 AND FORM 990-T. THE ORGANIZATION ALSO MAKES ITS FORM 990 AVAILABLE AT THE WEBSITE GUIDESTAR.ORG
Form 990, Part XI, Line 9, Other changes in net assets or fund balances	TRANSFERS TO AFFILIATED ORGANIZATIONS - 5546745, TEMPORARILY RESTRICTED CONTRIBUTIONS - 151411, NET ASSETS RELEASED FROM RESTRICTIONS - 72894, PERMANENTLY RESTRICTED CONTRIBUTION S - 296894, NET ASSET TRANSFERS FROM BHS TO BHSF FOR ENDOWMENT MATCHING PROGRAM - 101708

SCHEDULE R (Form 990)

Related Organizations and Unrelated Partnerships

OMB No 1545-0047

2013

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

Name of the organization
BAPTIST MEDICAL CENTER OF NASSAU INC

Employer identification number

59-3234723

Part I Identification of Disregarded Entities Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

Part I Identification of Disregarded Entities Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity

Part II Identification of Related Tax-Exempt Organizations Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) SOUTHERN BAPTIST HOSPITAL OF FLORIDA INC 800 PRUDENTIAL DR JACKSONVILLE, FL 32207 59-0747311	HOSPITAL	FL	501(C)(3)	3	BAPTIST HEALTH SYSTEM INC		No
(2) BAPTIST HEALTH SYSTEM INC 841 PRUDENTIAL DR STE 1602 JACKSONVILLE, FL 32207 59-2487136	MGT ASSISTANCE TO HOSPITALS	FL	501(C)(3)	11 - Type II	NA		No
(3) BAPTIST MEDICAL CENTER OF THE BEACHES INC 1350 13TH AVE S JACKSONVILLE BEACH, FL 32250 59-2980620	HOSPITAL	FL	501(C)(3)	3	BAPTIST HEALTH SYSTEM INC		No
(4) BAPTIST HEALTH SYSTEM FOUNDATION INC 841 PRUDENTIAL DR 13TH FLOOR JACKSONVILLE, FL 32207 59-2487135	FUNDRAISING ACTIVITIES TO SUPPORT HOSPITALS	FL	501(C)(3)	7 - Type I	BAPTIST HEALTH SYSTEM INC		No
(5) BAPTIST HEALTH PROPERTIES INC 3563 PHILIPS HWY BLD F STE 608 JACKSONVILLE, FL 32207 59-2487133	PROPERTY MGT FOR HEALTHCARE SYSTEM	FL	501(C)(3)	11 - Type I	BAPTIST HEALTH SYSTEM INC		No
(6) BAPTIST HEALTH AMBULATORY SERVICES INC 3563 PHILIPS HWY BLD F STE 608 JACKSONVILLE, FL 32211 59-3410739	CANCER RESEARCH & EDUCATION FOR HEALTHCARE SYSTEM	FL	501(C)(3)	11 - Type I	BAPTIST HEALTH SYSTEM INC		No

Part III Identification of Related Organizations Taxable as a Partnership Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a partnership during the tax year.

Part IV Identification of Related Organizations Taxable as a Corporation or Trust Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.

Part V Transactions With Related Organizations Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule

1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

- a** Receipt of (i) interest (ii) annuities (iii) royalties or (iv) rent from a controlled entity
- b** Gift, grant, or capital contribution to related organization(s)
- c** Gift, grant, or capital contribution from related organization(s)
- d** Loans or loan guarantees to or for related organization(s)
- e** Loans or loan guarantees by related organization(s)
- f** Dividends from related organization(s)
- g** Sale of assets to related organization(s)
- h** Purchase of assets from related organization(s)
- i** Exchange of assets with related organization(s)
- j** Lease of facilities, equipment, or other assets to related organization(s)
- k** Lease of facilities, equipment, or other assets from related organization(s)
- l** Performance of services or membership or fundraising solicitations for related organization(s)
- m** Performance of services or membership or fundraising solicitations by related organization(s)
- n** Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)
- o** Sharing of paid employees with related organization(s)
- p** Reimbursement paid to related organization(s) for expenses
- q** Reimbursement paid by related organization(s) for expenses
- r** Other transfer of cash or property to related organization(s)
- s** Other transfer of cash or property from related organization(s)

	Yes	No
1a		No
1b		No
1c	Yes	
1d		No
1e		No
1f		No
1g		No
1h		No
1i		No
1j		No
1k	Yes	
1l		No
1m	Yes	
1n	Yes	
1o	Yes	
1p	Yes	
1q	Yes	
1r	Yes	
1s	Yes	

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved

Part VI Unrelated Organizations Taxable as a Partnership Complete if the organization answered "Yes" on Form 990, Part IV, line 37.

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

Part VII Supplemental Information

Provide additional information for responses to questions on Schedule R (see instructions)

Return Reference	Explanation
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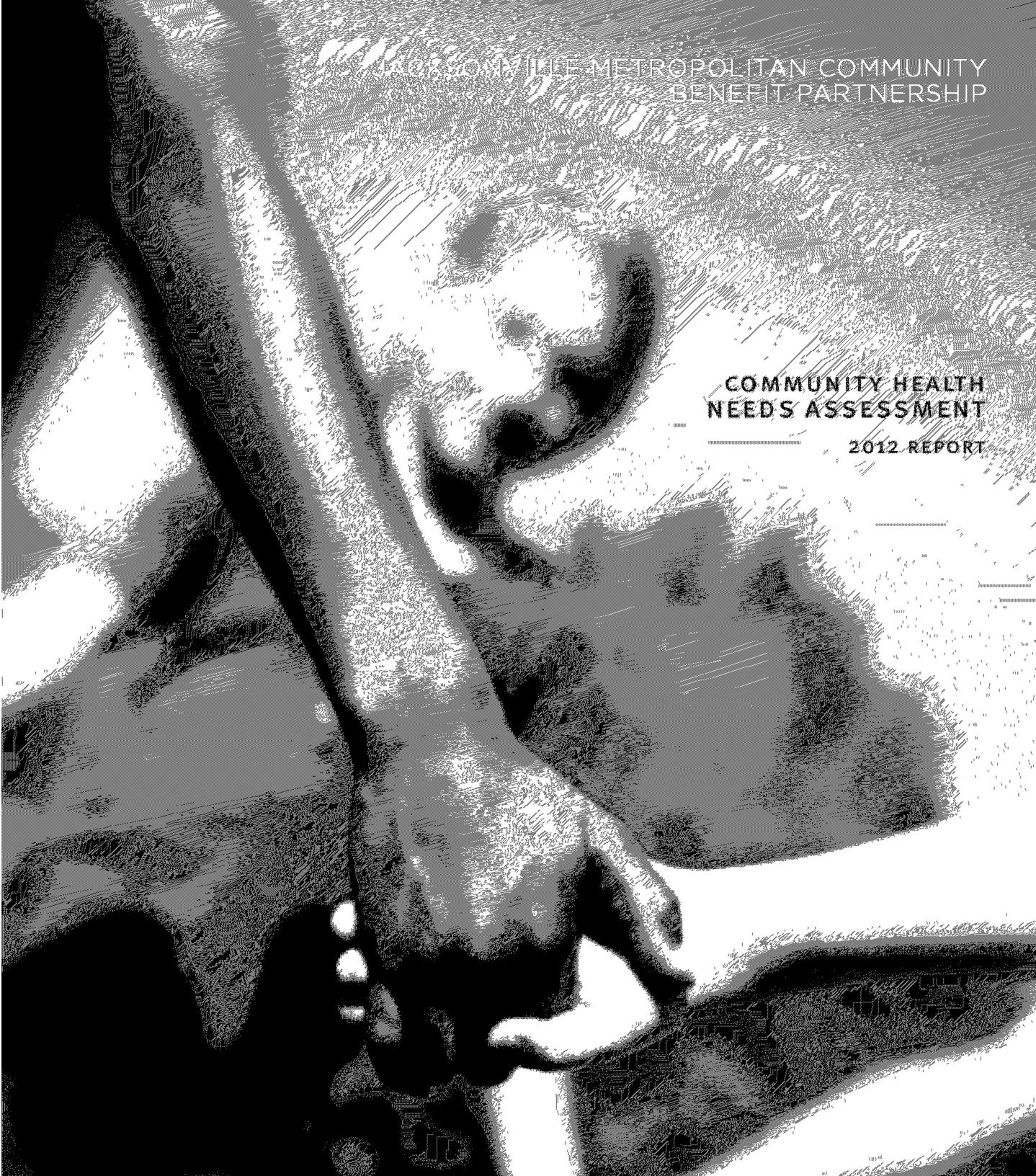
Schedule R (Form 990) 2013

Additional Data

Software ID: 13000248
Software Version: 2013v3.1
EIN: 59-3234721
Name: BAPTIST MEDICAL CENTER OF NASSAU INC

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c) (3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
(1) SOUTHERN BAPTIST HOSPITAL OF FLORIDA INC 800 PRUDENTIAL DR JACKSONVILLE, FL 32207 59-0747311	HOSPITAL	FL	501(C)(3)	3	BAPTIST HEALTH SYSTEM INC		No
(1) BAPTIST HEALTH SYSTEM INC 841 PRUDENTIAL DR STE 1602 JACKSONVILLE, FL 32207 59-2487136	MGT ASSISTANCE TO HOSPITALS	FL	501(C)(3)	11 - Type II	NA		No
(2) BAPTIST MEDICAL CENTER OF THE BEACHES INC 1350 13TH AVE S JACKSONVILLE BEACH, FL 32250 59-2980620	HOSPITAL	FL	501(C)(3)	3	BAPTIST HEALTH SYSTEM INC		No
(3) BAPTIST HEALTH SYSTEM FOUNDATION INC 841 PRUDENTIAL DR 13TH FLOOR JACKSONVILLE, FL 32207 59-2487135	FUNDRAISING ACTIVITIES TO SUPPORT HOSPITALS	FL	501(C)(3)	7 - Type I	BAPTIST HEALTH SYSTEM INC		No
(4) BAPTIST HEALTH PROPERTIES INC 3563 PHILIPS HWY BLD F STE 608 JACKSONVILLE, FL 32207 59-2487133	PROPERTY MGT FOR HEALTHCARE SYSTEM	FL	501(C)(3)	11 - Type I	BAPTIST HEALTH SYSTEM INC		No
(5) BAPTIST HEALTH AMBULATORY SERVICES INC 3563 PHILIPS HWY BLD F STE 608 JACKSONVILLE, FL 32211 59-3410739	CANCER RESEARCH & EDUCATION FOR HEALTHCARE SYSTEM	FL	501(C)(3)	11 - Type I	BAPTIST HEALTH SYSTEM INC		No



JACKSONVILLE METROPOLITAN COMMUNITY
BENEFIT PARTNERSHIP

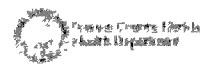
COMMUNITY HEALTH
NEEDS ASSESSMENT
2012 REPORT



BROOKS
Rehabilitation



Shands Jacksonville



COMMUNITY HEALTH NEEDS ASSESSMENT: 2012 REPORT



This comprehensive community health needs assessment conducted through the Health Planning Council of Northeast Florida has been an extremely worthwhile endeavor in helping us identify specific gaps in health care that currently exist in our community. Since we all share a common commitment to providing access to high quality health care beyond our own walls, we are pleased to now have this information that can be used as we move forward to develop solutions to improve the lives of Northeast Florida residents.

A. Hugh Greene
President and CEO
Baptist Health



Brooks Rehabilitation is pleased to participate in this coordinated community health needs assessment. By working with the Health Planning Council on this effort, all of the health systems benefit from this comprehensive analysis of the needs in our community. This approach enables us to better address these needs in a collaborative manner and avoid duplication of efforts.

This assessment provides Brooks Rehabilitation with a road map to better serve people living with or at risk for disabilities and helps us determine how we can apply our resources to achieve maximum community impact, especially for those with the greatest need. It also allows us, together with our partners in the community, to focus on the most pressing concerns resulting in an improvement in the quality of life and makes Northeast Florida a healthier place to live.

Douglas M. Baer
President and CEO
Brooks Rehabilitation



The community health needs assessment is representative of the shared values that exist among the hospitals and health systems that have come together to complete this very important work. It is demonstrative of the collaboration, commitment and excellence that exists and must prevail as we now take steps individually and collectively to address the most pressing health needs of the communities in which we live and serve. Mayo Clinic is proud to be part of this unprecedented and collaborative endeavor.

William C. Rupp, MD
CEO
Mayo Clinic Florida

COMMUNITY HEALTH NEEDS ASSESSMENT: 2012 REPORT



Working collaboratively with other hospitals through the Health Planning Council of Northeast Florida to develop a comprehensive community needs assessment demonstrates a commitment to improving the health and well-being of our community. Identified health disparities and gaps will better guide our efforts and resources, which will have exponential benefits to the community. Shands Jacksonville Medical Center is committed to addressing these needs in conjunction with our other health care partners. This has been an excellent process and a great example of synergy.

Jim Burkhardt, MHIA, D.Sc., FACHE
President and CEO
Shands Jacksonville



Together, with other area hospitals, we have completed this community health needs assessment to determine if we are on target in meeting the needs of the most vulnerable within our community. The results of the assessment were no surprise, but rather served as affirmation that St. Vincent's has been, and continues to be, deeply integrated and in touch with the needs of the communities in which we serve.

We have selected some of the most critical health issues and have built corresponding measured action plans to provide care and a better quality of life for so many.

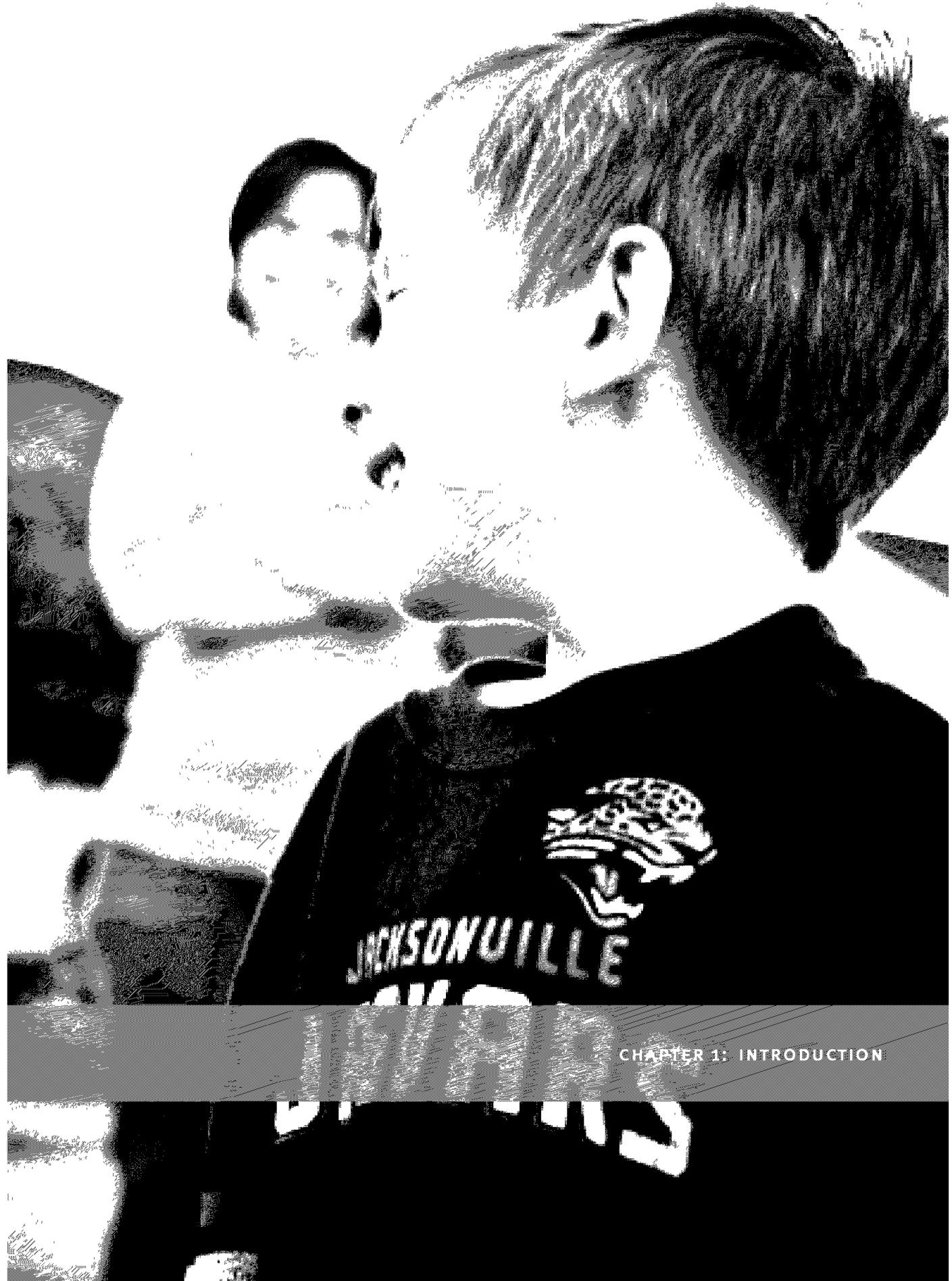
Moody Chisholm
President and CEO
St. Vincent's HealthCare

TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION	7
ABOUT THE JACKSONVILLE METROPOLITAN COMMUNITY BENEFIT PARTNERSHIP	8
SOCIAL-ECOLOGICAL MODEL	9
INTRODUCTION TO COMMUNITY BENEFIT	10
CHAPTER 2: METHODOLOGY	13
DEFINING THE COMMUNITY	14
PRIMARY RESEARCH	14
COMMUNITY HEALTH SURVEY	14
FOCUS GROUPS / ROUNDTABLE DISCUSSIONS	16
SECONDARY RESEARCH	16
HEALTH CARE, POPULATION HEALTH, HEALTH-RELATED QUALITY OF LIFE INDICATORS	16
COUNTY HEALTH RANKINGS	17
MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP)	17
OTHER COMMUNITY DATA	17
CHAPTER 3: COMMUNITY PROFILE	18
GEOGRAPHY	19
DEMOGRAPHICS	19
POPULATION	19
AGE	19
GENDER	19
RACIAL DEMOGRAPHICS	19
ETHNICITY	20
LANGUAGE	20
KEY FINDINGS	20
ECONOMIC CONDITIONS	23
INCOME	23
POVERTY	23
EMPLOYMENT	23
HOUSING	24
HOMELESSNESS	24
KEY FINDINGS	24
SCHOOL AND STUDENT POPULATION	28
STUDENT RACE AND ETHNICITY	28
GRADUATION RATES	29
SCHOOL ABSENCE	29
HOMELESS STUDENTS	29
GANG ACTIVITY	29
KEY FINDINGS	29
PUBLIC SAFETY/CRIME	32
UNINTENTIONAL INJURY	32
MOTOR VEHICLE CRASH	32
DOMESTIC VIOLENCE	33
AGGRAVATED ASSAULT	33
FORCIBLE SEX OFFENSES	33
HOMICIDE	33
SPORTS-RELATED INJURIES	33
JUVENILE CRIME	34
KEY FINDINGS	34
VITAL STATISTICS	49
LEADING CAUSES OF DEATH	49

CHAPTER 4: BUILT ENVIRONMENT	51
NATURAL AMENITIES SCALE	52
AMERICAN LUNG ASSOCIATION: STATE REPORT CARD	52
BLOOD LEAD LEVELS	52
WATER FLUORIDATION	52
KEY FINDINGS	53
CHAPTER 5: ACCESS TO FOOD	55
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)	56
WOMEN, INFANTS AND CHILDREN (WIC)	56
ACCESS TO FOOD SOURCES	57
KEY FINDINGS	57
CHAPTER 6: HEALTH CARE ACCESS	64
QUALITY OF CARE	65
KEY FINDINGS	65
HEALTH CARE PROVIDERS AND FACILITIES	66
ACCESSING HEALTH CARE OR PHYSICIANS	66
DELAYS IN ACCESSING HEALTH CARE OR PHYSICIANS	66
DELAYS IN TESTS AND SCREENINGS	67
REASONS FOR DELAYS IN ACCESSING HEALTH CARE	67
KEY FINDINGS	67
HEALTH INSURANCE	72
MEDICARE AND MEDICAID	73
FLORIDA KIDCARE	73
KEY FINDINGS	73
EMERGENCY DEPARTMENT VISITS	78
KEY FINDINGS	78
DENTAL COVERAGE AND PROVIDER SUPPLY	80
KEY FINDINGS	81
HEARING AND VISION PROVIDER SUPPLY	82
BARRIERS TO CARE	83
AFFORDABILITY	83
TRANSPORTATION AS A BARRIER	83
KEY FINDINGS	84
CAREGIVERS	84
KEY FINDINGS	85
CHAPTER 7: HEALTHY LIFESTYLES AND BEHAVIORS	86
PHYSICAL ACTIVITY	87
KEY FINDINGS	87
IMMUNIZATIONS AND SCREENINGS	88
VISION	88
ORAL HEALTH	88
CHILDHOOD IMMUNIZATIONS	89
INFLUENZA AND PNEUMONIA	89
KEY FINDINGS	89
CHAPTER 8: HEALTH CONDITIONS AND DISEASES	95
CHRONIC DISEASES	96
CANCER	96
HEART DISEASE AND STROKE	96
RESPIRATORY DISEASES	96
DIABETES	96
KEY FINDINGS	97

BEHAVIORAL HEALTH	112
KEY FINDINGS	113
SUBSTANCE ABUSE	116
SMOKING	116
ALCOHOL	116
KEY FINDINGS	116
OBESITY	120
KEY FINDINGS	120
SEXUALLY TRANSMITTED DISEASES	122
SYPHILIS, GONORRHEA, CHLAMYDIA	122
HIV/AIDS	122
KEY FINDINGS	122
INFECTIOUS DISEASES	125
MATERNAL AND INFANT HEALTH	126
EARLY PRENATAL CARE	126
INFANT MORTALITY	126
PRETERM BIRTHS	126
LOW BIRTH WEIGHT BABIES	126
TEEN MOTHERS	126
KEY FINDINGS	127
CHAPTER 9: RESIDENTS WITH DISABILITIES	135
RESIDENTS WITH DISABILITIES	136
ADULTS WITH DISABILITY	136
PERSONS WITH VARIOUS DIFFICULTIES	136
KEY FINDINGS	136
CHAPTER 10: NEEDS ASSESSMENT SUMMARIES BY COUNTY	142
CLAY COUNTY NEEDS ASSESSMENT SUMMARY	143
DUVAL COUNTY NEEDS ASSESSMENT SUMMARY	146
NASSAU COUNTY NEEDS ASSESSMENT SUMMARY	150
PUTNAM COUNTY NEEDS ASSESSMENT SUMMARY	153
ST. JOHNS COUNTY NEEDS ASSESSMENT SUMMARY	157
CHAPTER 11: PRIORITIZING THE NEEDS	160
PEDIATRIC OUTCOMES	161
COMPREHENSIVE REHABILITATION OUTCOMES	161
ACUTE CARE OUTCOMES	162
PRIORITY-SETTING AND RANKING	163
COMMUNITY ASSESTS TO ADDRESS THE NEEDS	164
NEEDS NOT ADDRESSED IN ASSESMNT	166
COMMUNITY NEEDS ASSESSMENT TAKEAWAYS	166
APPENDICES	167
COMMUNITY HEALTH SURVEY 2012 DEMOGRAPHICS	168
COMMUNITY HEALTH FOCUS GROUP 2012 DEMOGRAPHICS	172
JACKSONVILLE METROPOLITAN COMMUNITY BENEFIT PARTNERSHIP SHANDS MINORITY FOCUS GROUP – THEMES AND SUMMARY	175
HEALTH NEEDS ASSESSMENT FOCUS GROUP BROOKS REHABILITATION – SUMMARY AND CONCLUSION	177
HEALTH NEEDS ASSESSMENT FOCUS GROUP MAYO CLINIC – SUMMARY AND CONCLUSIONS	182
JACKSONVILLE METROPOLITAN COMMUNITY BENEFIT PARTNERSHIP BAPTIST HEALTH – SUMMARY AND CONCLUSIONS	186
JACKSONVILLE METROPOLITAN COMMUNITY BENEFIT PARTNERSHIP ST. VINCENT'S HEALTHCARE – SUMMARY AND CONCLUSIONS	189



CHAPTER 1: INTRODUCTION

ABOUT THE JACKSONVILLE METROPOLITAN COMMUNITY BENEFIT PARTNERSHIP

Northeast Florida is home to several hospitals that are ranked in the nation's top 100 and is one of only three locations in the nation for the renowned Mayo Clinic. Also based in Jacksonville is the University of Florida Proton Therapy Institute (www.floridaproton.org), one of only 10 (in 2011) proton therapy cancer treatment centers located in the United States. The health care industry in Jacksonville contributes a total of nearly \$7.4 billion in direct economic impact. When accounting for related industries, the total is nearly \$25 billion.

In July 2011, leaders from Baptist Health, Brooks Rehabilitation, the Clay County Health Department, the Duval County Health Department, Mayo Clinic, the Nassau County Health Department, the Putnam County Health Department, Shands Jacksonville Medical Center, St. Vincent's HealthCare and

came together and formed the Jacksonville Metropolitan Community Benefit Partnership (The Partnership) to conduct the first-ever multi-hospital system and public health sector collaborative community health needs assessment. The Partnership consists of a network of five health care systems (nine nonprofit hospitals) and four public health departments that stand for a shared voice and vision of improving population health and wellness in the Jacksonville Metropolitan area. The Partnership's vision is to improve population health in the region by eliminating the gaps that prevent access to quality, integrated health care and to improve access to resources that support a healthy lifestyle.



The Health Planning Council of Northeast Florida works for a better balance of public health policies directed at community development including the equitable provision of essential public health services,

the protection of environmental resources; and the promotion of economic sustainability. Their role as an unbiased community convener affords them the ability to mobilize civic leaders, businesses and citizens to play a meaningful role in creating healthy communities that enrich people's lives.

In 1982, Florida State Statute Title XXIX Public Health Chapter 408.033, and 11 local health councils, including the Health Planning Council of Northeast Florida (Health Planning Council), were established. The Health Planning Council has served as a reliable and progressive agency serving Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia Counties. The Health Planning Council is the only non-partisan, non-governmental planning organization in the region mandated to dedicate resources and expertise to regional health utilization data management; manage health-related quality of life indicators and health planning and research; conduct community connecting projects; and provide input on proposed land use and environmental development projects to local government.

The Health Planning Council conducts numerous community health planning/assessment and community connecting projects across Florida. Since each community is unique, our approach to better understanding a community's need is aligned with the Social-Ecological Model. The Social-Ecological Model is a comprehensive approach to health and urban planning that not only addresses a community's or individual's risk factors, but also the norms, beliefs, and social and economic systems that create the conditions for poor community health outcomes.

SOCIAL - ECOLOGICAL MODEL



In partnership with the Health Planning Council, Ulrich Research assisted with survey design, data analysis and the presentation of survey findings. Established in 1981, Ulrich Research has experience in a wide variety of research methods including telephone surveys, mail surveys, data processing, personal interviews, focus groups, database enhancement, market profiling and secondary research.

Participating Members of the Jacksonville Metropolitan Community Benefit Partnership

Audrey Moran

Baptist Health/Wolfson Children's Hospital

Michelle Leak

Mayo Clinic

Lynn Sherman

Baptist Health/Wolfson Children's Hospital

Nancy Mills

Clay County Health Department

Mary Alice Phelan

St. Vincent's HealthCare

Tim Lawther

Duval County Health Department

David Pringle

St. Vincent's HealthCare

Heather Huffman

Nassau County Health Department

Robin Bass

Shands Jacksonville Medical Center

Robin Wright

Putnam County Health Department

Marion Anderson

Brooks Rehabilitation

INTRODUCTION TO COMMUNITY BENEFIT

Community benefit programs and services are integral parts of the mission of nonprofit health care organizations and are the basis of tax exemption¹. They intend to 1) improve access to health care, 2) enhance the health of the community; 3) advance medical and health knowledge, and, 4) relieve or reduce the burden of government on other community efforts. The Affordable Care Act (2010) includes provisions that will increase insurance payments to hospitals, resulting in fewer patients relying on charity care. To ensure that nonprofit hospitals continue to provide community benefit, hospitals seeking to maintain tax-exempt status must:

- give increased attention to working with others to determine community health needs and take action to meet those needs, and
- implement financial assistance and billing and collection policies that protect consumers²

Section 501(r), added to the tax code by the Affordable Care Act, imposes new requirements on hospital organizations. Each 501(c)(3) hospital organization is required to meet four general requirements on a facility-by-facility basis. The requirements are to

- establish written financial assistance and emergency medical care policies,
- limit amounts charged for emergency or other medically necessary care to individuals eligible for assistance under the hospital's financial assistance policy,
- make reasonable efforts to determine whether an individual is eligible for assistance under the hospital's financial assistance policy before engaging in extraordinary collection actions against the individual, and
- conduct a community health needs assessment at least once every three years³

Community health needs assessments enable practitioners, managers and policy makers to identify those individuals in greatest need and to ensure that health care resources are used to maximize health improvement. The assessment is not an end, but a process that

- describes the health status within the defined geographic area,
- identifies the major risk factors and causes of illness, and
- allows for the formulation of actions needed to address those risk factors and causes⁴

In addition to satisfying regulatory requirements of federal and state agencies and local funders, the community health needs assessment represents an unprecedented effort and key opportunity to bring together hospital data, population health, health-related quality of life indicators and community member input to provide a more detailed and complete profile of community health needs. The long-term goal is to achieve regional collaboration that will serve as an opportunity for optimal leverage of resources, setting (and managing) regional health priorities, and developing regional collective impact strategies among all health-related stakeholders.

The health of a community is determined by the physical, mental, environmental, spiritual and social well being of all community residents. Achieving such a complex state of being is one that requires an equally complex understanding of the determinants of each of these aspects of health. A community health needs assessment—driven by community input—is a systematic approach to collecting, analyzing and using this complex data and information to identify priority areas for health improvement efforts. This community health needs assessment report serves as a baseline of the health status of the five counties identified by The Partnership as the geography of focus: Duval, Nassau, Clay, Putnam and northern St. Johns Counties located in Northeast Florida.

¹ Catholic Health Association of the United States. Community Benefit. <http://www.chausa.org/CommunityBenefit/>

² The Hilltop Institute (2011) Hospital Community Benefits after the ACA: The Emerging Federal Framework. <http://www.HillTopInstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-HCBAIssueBrief-January2011.pdf>

³ Internal Revenue Service (2012) New Requirements for 501(c)(3) Hospitals Under the Affordable Care Act. <http://www.irs.gov/charities/charitable/article/0,,id=236275,00.html>

⁴ World Health Organization (2001) Community Health Needs Assessment: An Introductory Guide for the Family Health Nurse in Europe. http://www.euro.who.int/_data/assets/pdf_file/0018/102249/E73494.pdf

Using national strategies including *Healthy People 2020*, National Prevention Strategies and The Robert Wood Johnson Foundation's County Health Rankings as a framework for the community health needs assessment, data were compiled from the most up-to-date publicly available resources and primary research with targeted populations who face more challenges in receiving health care and maintaining optimum health and well being. Health status improvement and evidence-based interventions will be tracked and measured using the Northeast Florida Counts health-related quality of life indicator platform.

In Florida, all 67 county health departments are required to initiate a countywide, community health assessment that determines public health priorities for the next three to five years MAPP, the acronym for "Mobilizing for Action through Planning and Partnerships," is recommended by many national and state public health organizations including the National Association for City and County Health Officials (NACCHO) and the Florida Department of Health as a best practice for health assessment and planning. MAPP is built on principles of broad community engagement and strategic planning, which prepare community partners to act together to address prioritized health issues and improve community health. All county health departments located in the five geographic focus areas targeted for the community health needs assessment have completed their MAPP priorities at the time of The Partnership's community health needs assessment. It was imperative that the health priorities identified in the five MAPP assessments be integrated and supported in this report to avoid the creation of duplicative or competing community health improvement plans.

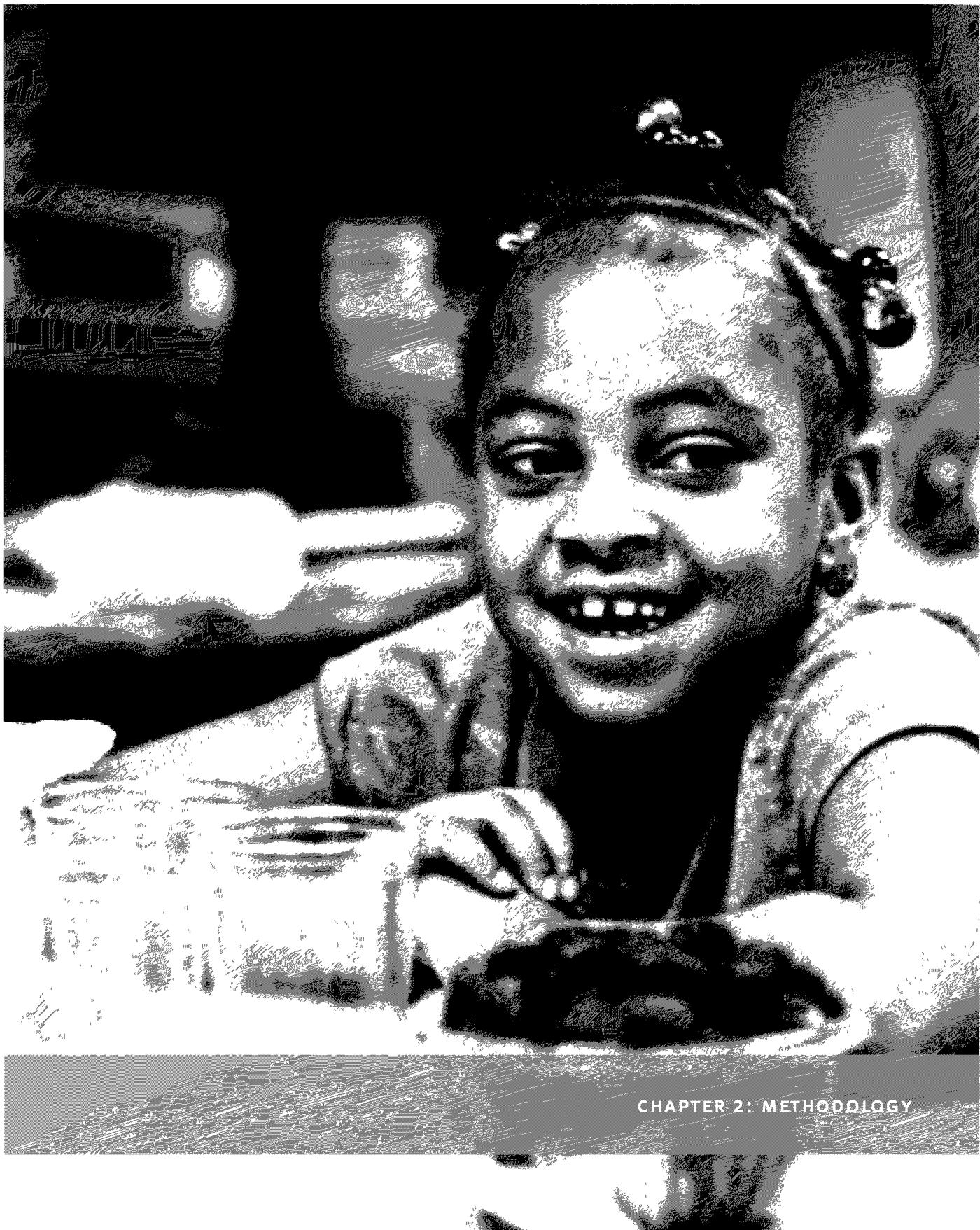
The findings from The Partnership's community health needs assessment document the need for improvement in social determinants of health, health status, access to care and built environment elements across the five counties. The five-county area falls short of *Healthy People 2020* goals in multiple areas, and is worse than state and national statistics in many others. Disparities in access and preventive care as well as food access demonstrate the need for concerted action in order to achieve health equity and overall health improvement for the entire population. Health disparities are differences in health outcomes between groups that reflect social inequalities. According to the Centers for Disease Control and Prevention's (CDC) 2011 *Health Disparities and Inequalities Report*, "Since the 1980s, our nation has made substantial progress in improving residents' health and reducing health disparities, but ongoing racial/ethnic, economic and other social disparities in health are both unacceptable and correctable."

Throughout this report, we will highlight health disparities in the identified community health needs assessment region. The report also acknowledges the expertise of the Health Planning Council for managing the assessment, including convening, data mining, facilitating and securing the technical and research resources to complete the project. The Health Planning Council is a regional nonprofit that develops regional, unbiased research and evidence-based initiatives that promote healthy communities and lifestyles, and improve accessible, quality health care.

The community needs assessment report will be publicly accessible by way of Northeast Florida Counts and the Community Health Needs Assessment (CHNA) web-based platform located on each hospital's organizational website as well as this printed report. The CHNA system is a customizable, web-based information system that provides a continuously updated "living" needs assessment and provides each of the participating hospitals with a CHNA template/deliverable to help meet new Internal Revenue Code Section 501(r), for conducting community health needs assessments.

Fully embeddable within each hospital's existing website, the CHNA system will provide a dashboard of indicators that drive community health needs assessments and will contain a large database of promising practices that inform evidenced-based community benefit programs. The CHNA system is designed to work closely with the existing Northeast Florida Counts platform. Together, the CHNA system and Northeast Florida Counts provide hospitals access to high quality community health assessment data, improved health indicator tracking, best practice sharing and community development tools that function together to help improve the health and environmental sustainability of the community.

The implementation will include an embedded CHNA landing page configured specifically for Brooks Rehabilitation, Mayo Clinic, St Vincent's HealthCare – Riverside and Southside, Shands Jacksonville Medical Center, Baptist Health Jacksonville, Beaches, South and Nassau, and Wolfson Children's Hospital. These will include county- and selected sub-county level data views for Clay, Duval, Nassau, Putnam and St. Johns Counties in Florida.



CHAPTER 2: METHODOLOGY

DEFINING THE COMMUNITY

Through community health and utilization data, as well as internal-facility targeted service delivery geography, the Jacksonville Metropolitan Community Benefit Partnership (The Partnership) and the Health Planning Council recognized the disparity in health status and health risk between those in the highest income levels and the lowest, as well as between the insured and uninsured. Those in the lowest income level without insurance have the greatest health needs and are most challenged in gaining access to high quality, affordable health care. In addition, the community health needs assessment identified children and youth as the population most at risk for adopting poor health behaviors, but with the greatest opportunity for successful intervention. Each of the participating hospital's Implementation Strategy and Community Benefit Plan will address the health needs of the broader population with a special focus on those members of the population who demonstrate the greatest need.

Each of the participating hospitals in The Partnership discussed and agreed upon their respective targeted communities. Internal hospital patient census, existing community benefit programs, as well as a secondary data and community scans facilitated the specific community audiences to engage for the primary data collection. The targeted community audience for primary data collected included, but was not limited to, adults and children living below the poverty level, homeless/transient, unwed mothers, the disabled and their caregivers, children and adolescents, senior citizens, adults and children with a variety of education levels, adults and children from diverse racial identification, and health care professionals.

- Baptist Medical Center Jacksonville - Duval County
- Baptist Medical Center Beaches - Duval County (specifically, Atlantic, Neptune and Jacksonville Beaches)
- Baptist Medical Center Nassau - Nassau County
- Baptist Medical Center South - Duval County and Northern St. Johns County
- Brooks Rehabilitation - Duval County and St. Johns County
- Mayo Clinic - Duval County
- St. Vincent's Medical Center Riverside - Duval County, Clay County and Putnam County
- St. Vincent's Medical Center Southside - Duval County
- Shands Jacksonville Medical Center - Duval County
- Wolfson Children's Hospital - 

PRIMARY RESEARCH

Community Health Survey

The Community Health Survey was developed and administered to a broad and varied range of residents living in the targeted five-county community. The survey contained questions regarding perceived quality of life and health of the community, barriers to health care, use of health care, health care needs and demographic information. The survey had two screening or "filter" questions to redirect two specific segments of population to a different set of questions if they qualified. The first filter question asked the respondent, "Do you have any children under the age of 18 in your home?" If they responded YES, the respondents were asked a separate set of survey questions that were child- or adolescent-focused. If they responded NO, they continued with the standard set of survey questions. A second filter question asked the respondent, "Do you take care of a person with disabilities or are you a person with disabilities?" If they responded YES, the respondents were asked a separate set of survey questions that focused on caregiving and disability needs. If they responded NO, they continued with the standard set of survey questions.

The Community Health Survey was completed between February 6, 2012, and March 6, 2012. The survey was conducted in two phases: 1) an Internet panel-based survey conducted from February 6 through February 8, 2012, and 2) a telephone survey completed between February 29 and March 6, 2012. A total of 935 persons in Northeast Florida participated in the survey. The survey included participants from Clay, Duval, Nassau and St. Johns Counties.

An Internet panel method was used in order to reach the largest possible number of qualified respondents within the limits of the project budget. The panel survey was conducted through Research Now, a global provider of pre-recruited consumer and business respondents who have agreed to participate in market research surveys. With more than six million panelists worldwide, Research Now can provide access to consumers at the MSA or county level for studies that have a relatively low incidence of qualification. A total of 822 respondents participated in the Internet panel survey.

Internet panel surveys do not reach households that do not have access to the Internet. Additionally, they tend to underrepresent lower-income, less educated and minority households. A randomized telephone survey sample was designed to address these gaps by targeting households with household incomes below \$25,000 and two age groups: 1) persons ages 18 to 34 and persons ages 75 and older. These age ranges were underrepresented in the online survey sample. A total of 113 interviews were completed by telephone.

The average length of the online version of the survey was 18 minutes, compared to 25 minutes on the telephone. A \$10.00 gift card was offered to the telephone survey respondents to encourage their cooperation and patience with the interview.

The final sample is not a true probability sample with known ranges of sampling error. It was designed to meet the objectives of the research in the most cost-effective and efficient manner possible. If the Community Health Survey had been based on a true probability sample, the range of sampling error would be plus or minus 3.2 percent at the 95 percent level of confidence. Because at least 28 percent of U.S. households now have no landline phone service, traditional RDD telephone samples do not provide coverage of all households. It has become more common to use multiple modes of sampling and interviewing, and then to statistically weight the combined survey samples to most closely represent the target population.

The Community Health Survey sample was  represent the population of adults ages 18 and older in Clay, Duval, Nassau and St. Johns Counties by age range. The following table shows 2012 estimates of population by age from Claritas, Inc., the unweighted distribution of respondents by age, the statistical weight applied and the weighted distribution of respondents. Putnam County residents were not included in the sample due to small sample sizes.

THE COMMUNITY HEALTH SURVEY SAMPLE

AGE RANGE	QUALITATIVE ESTIMATES, 2012		RAW SURVEY DATA	PERCENT	WEIGHT APPLIED	WEIGHT DISTRIBUTION
	NUMBER	PERCENT				
18 TO 24	123,524	12%	48	5%	2,36640	12%
25 TO 34	189,136	19%	144	15%	1,20778	19%
35 TO 44	187,011	18%	126	13%	1,36482	18%
45 TO 54	201,993	20%	170	18%	1,09261	20%
55 TO 64	155,027	15%	229	24%	0,62251	15%
65 TO 74	85,700	8%	159	17%	0,49563	8%
75 AND OLDER	74,406	7%	59	6%	1,15967	70%
TOTAL	1,016,797	100%	935	100%		100%

*DATA ROUNDED

Focus Groups/Roundtable Discussions

After the completion of the surveys, focus groups/roundtable discussions were conducted in each of the five counties. Roundtable discussions are a participatory large-group approach (similar to focus groups) in which qualitative data are generated about an issue of importance through an interactive and collaborative process. The approach allows for the identification of needs and priorities among participants who have the knowledge and expertise to inform the research. A total of 148 individuals from communities located within Clay, Duval, Nassau, Putnam and St. Johns Counties gave their input on multiple dimensions of their communities, (not limited to).

- *Built Environment* Does the community infrastructure encourage or inhibit healthy lifestyles?
- *Local Economy* Are there adequate economic opportunities? How has the overall economic climate affected those in the community?
- *Barriers to Access* Are there services that are not accessible? Do those with Medicaid and Medicare face more barriers than those with private insurance?
- *Motivation for Healthy Living* What influences decisions about health?

SECONDARY RESEARCH

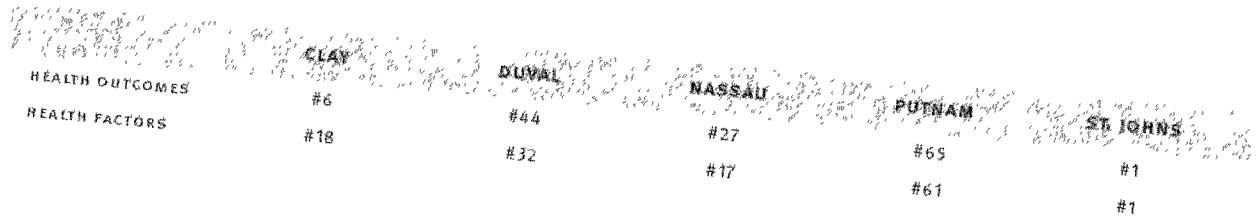
Health Care, Population Health, Health-Related Quality of Life Indicators

Secondary research consisted of gathering publicly available health-related data for the five counties. Whenever possible, data were collected at the county level. Sub-county level data were not a focus of this research but are provided where available.

An assessment of a community's health typically includes a profile of the community's population and characteristics. From there, mortality and morbidity indicators for the general population, as well as specific populations that experience a higher burden of disease and death, are reviewed. Prevention indicators are also an important component to consider.

County Health Rankings

A snapshot view of community health is provided by the County Health Rankings, an initiative of The Robert Wood Johnson Foundation and The University of Wisconsin Population Health Institute. Health rankings for each county in the nation are developed, using a variety of data for factors that impact the health of a community. These factors range from individual health behaviors to education to jobs to quality of health care to the environment.



Mobilizing for Action through Planning and Partnerships (MAPP)

Each county health department located in Clay, Duval, Nassau, Putnam and St. Johns Counties initiated a countywide, community health assessment that determined public health priorities for the next three to five years. The MAPP model was chosen to guide this comprehensive effort. MAPP is recommended by many national and state public health organizations including the National Association for City and County Health Officials (NACCHO) and the Florida Department of Health as a best practice for health assessment and planning. MAPP is built on principles of broad community engagement and strategic planning, which prepare community partners to act together to address prioritized health issues and improve community health. The Partnership's community health needs assessment reflects the priorities identified in the MAPP assessment and its corresponding community health improvement plan.

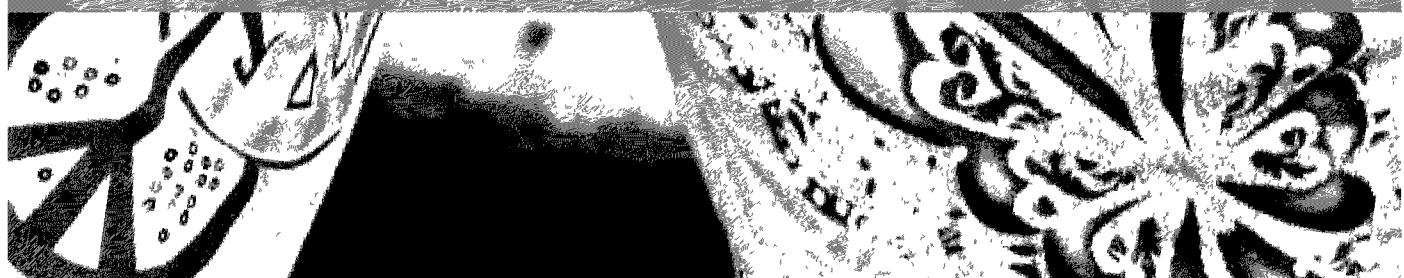


The Jacksonville Metropolitan area is known for its accessible regional data and community studies and reports. In the spirit of utilizing these resources and avoiding the duplication of these existing reports, the community health needs assessment accessed and used data from the following sources:

- Florida Medical Quality Assurance Inc. (FMQAI) Medicare Claim Data for Clay, Duval, Nassau and St. Johns Counties
- ElderSource's Area Service Needs Assessment for Clay, Duval, Nassau and St. Johns Counties
- ER and Admission Rates for Youth Sports-Related Concussions Report for Clay, Duval, Nassau and St. Johns Counties
- Florida Youth Risk Behavior Survey for Clay, Duval, Nassau, Putnam and St. Johns Counties
- The Florida Department of Health's State Health Improvement Plan (SHIP)
- Hospital Charity Care Data



CHAPTER 3: COMMUNITY PROFILE



GEOGRAPHY

The Partnership's community health needs assessment includes Clay, Duval, Nassau, Putnam and St. Johns Counties. A list of health-related quality of life indicators were selected based on the Institute of Medicine, *Healthy People 2020*, National Prevention Strategy recommendations and local community priorities. The indicators below are the focus of data retrieval and include the following categories:

Socioeconomic Indicators

- Population Demographics
- Economics
- Poverty
- Housing Statistics
- Homelessness
- Education
- Unintentional Injuries
- Crime
- Access to Food
- Vital Statistics (mortality rates)

Health-Related Indicators

- Sports-Related Injuries
- Environmental Health
- Nutrition
- Health Care Access
- Health Economics
- Dental Health
- Healthy Lifestyle
- Vision
- Chronic Disease Conditions
- Health Status (physically and mentally unhealthy days)
- Behavioral Health
- Substance Abuse
- Infectious Disease
- Maternal Health
- Disabilities



DEMOGRAPHICS

Population

The five counties of The Partnership's community health needs assessment region have a population of approximately 1.4 million, ranging from Putnam and Nassau Counties, each with a population around 74,000, to Duval County, with a population of nearly 900,000 (see Chart 3-1). The population of all counties in the region grew between 2000 and 2010. Growth ranged from 5.6 percent in Putnam County to 54.3 percent in St. Johns County.

Age

In all five counties of The Partnership's community health needs assessment, the largest portion of the population falls between the ages of 18 to 44. The age distribution of all five counties roughly resembles that of the state of Florida (see Chart 3-4). Putnam County has the highest percentage of residents ages 65 and older (18 percent).

Gender

In all five counties, females make up more of the population than males, but not by more than three percent. Clay, Putnam and Nassau Counties are closest to 50/50 (see Chart 3-5).

Racial Demographics

Racial demographics vary across The Partnership's community health needs assessment. Nassau and St. Johns Counties are nearly 90 percent Caucasian, with African-American populations around six percent. Duval County has the assessment region's largest African-American population at close to 30 percent. The Partnership's community health needs assessment region's largest Asian population percentage is also in Duval County (4.2 percent). For a breakdown of the racial mix in the assessment region, see Chart 3-2.

Ethnicity

Ethnicity, which is measured separately from race, likewise varies across the region. Hispanic / Latino residents make up 3.2 percent of Nassau County's population and 5.2 percent of St. Johns County's population. The other counties in the assessment region have a Hispanic / Latino population between 7.5 and 9.0 percent. The Hispanic / Latino population in the assessment region is significantly lower than that of the state (22.5 percent). (See Chart 3-3.)

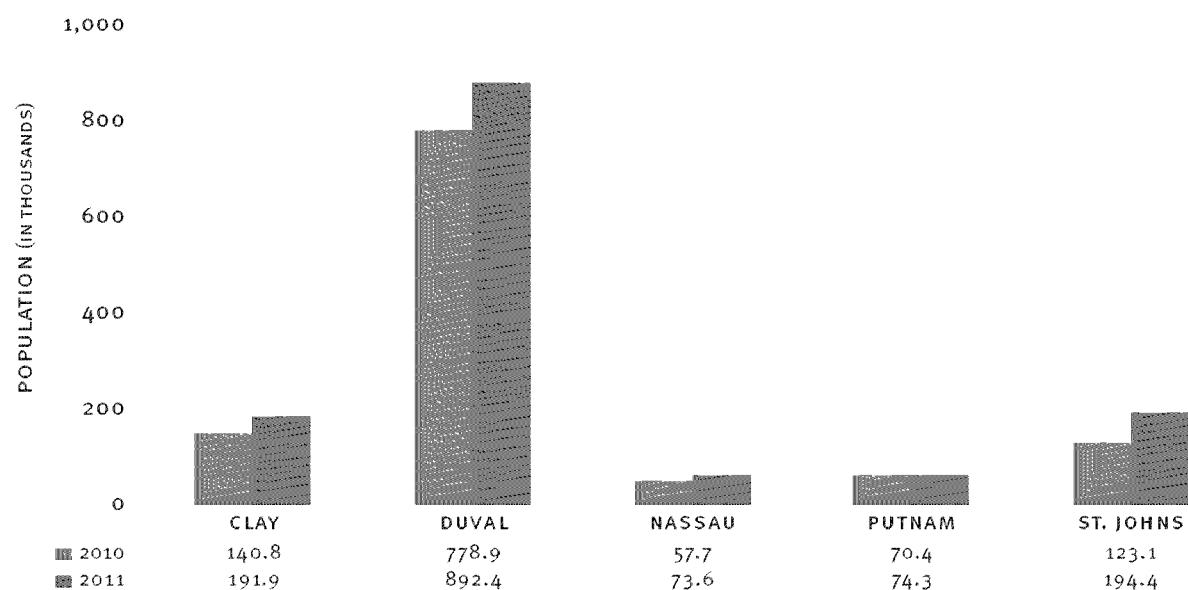
Language

The data gathered on languages other than English spoken at home includes residents ages five and older. The percentage for the state of Florida is 25.8, most likely a reflection of the large Hispanic / Latino population. Of the five counties in the assessment region, Duval County has the highest percentage (11.7 percent) and Nassau County has the lowest (4.2 percent). (See Chart 3-6.)

Key Findings

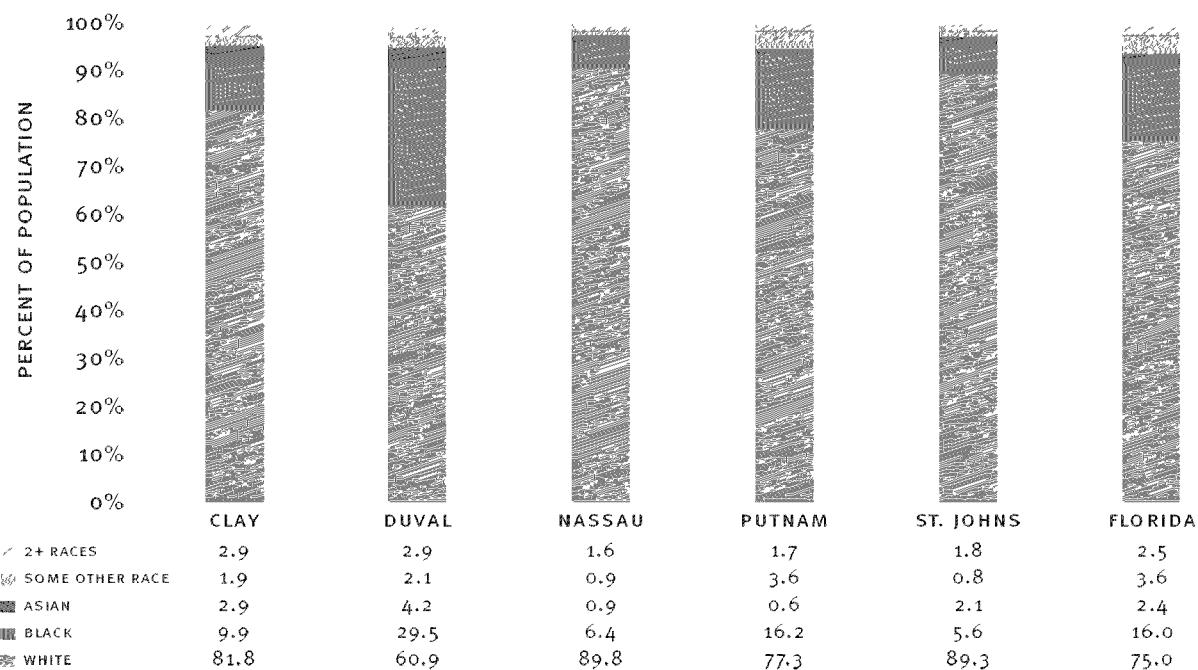
- From 2000 to 2010, the population in all five counties increased. The largest increase was seen in St. Johns County. Generally speaking, the age distribution of all counties is similar to that of the state of Florida overall. Additionally, the difference in the percentage of men and women is very small in every county of the assessment region.
- The racial diversity of the region is most evident in Duval County. The Hispanic / Latino population in the five-county region is much lower than that of the state of Florida, as is the percentage of those who speak languages other than English at home.

CHART 3-1 POPULATION ESTIMATES



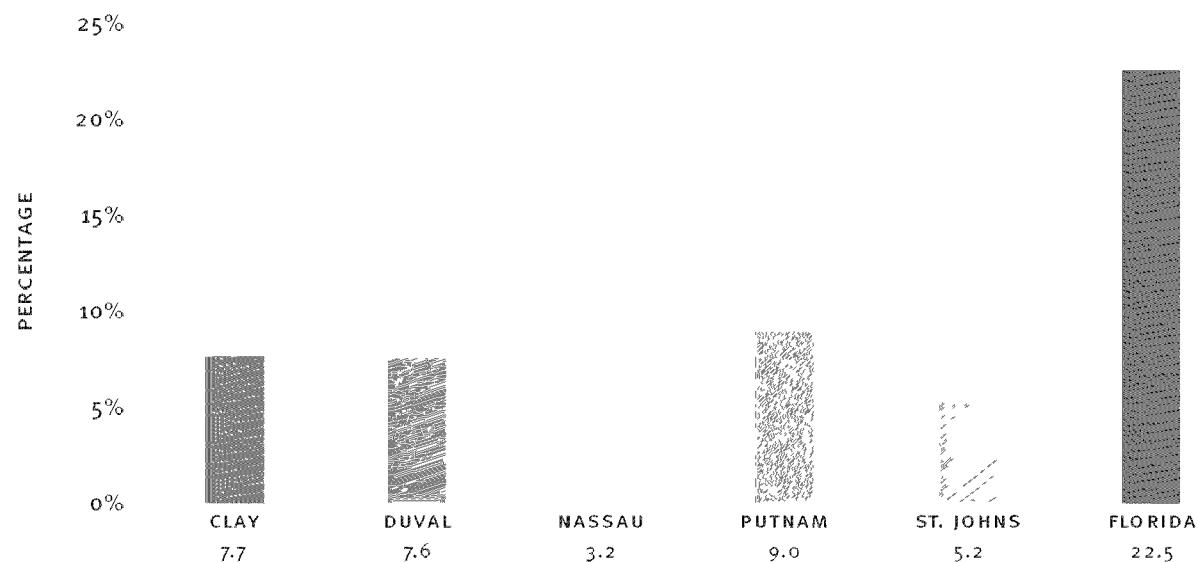
Source: U.S. Census Bureau 2010

CHART 3-2 POPULATION BY RACE



Source U.S. Census Bureau 2010

CHART 3-3 HISPANIC / LATINO POPULATION



Source U.S. Census Bureau 2010

CHART 3-4

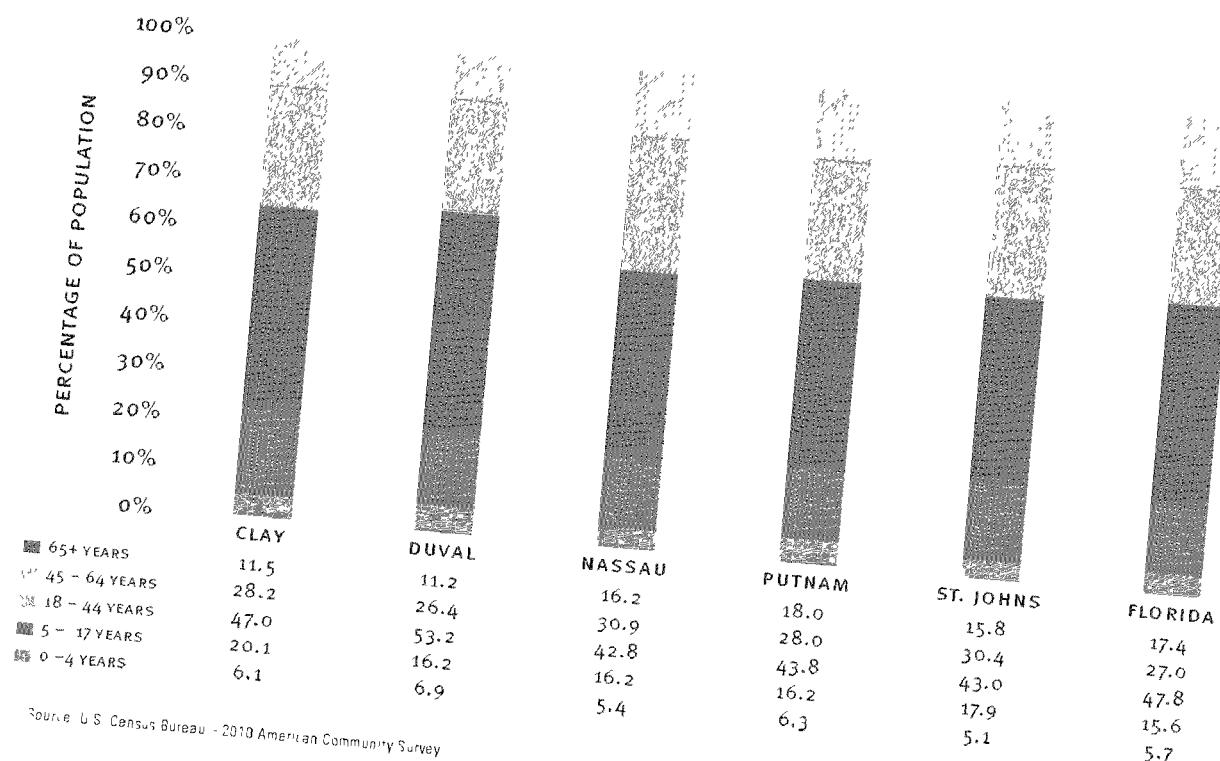


CHART 3-5 POPULATION BY GENDER

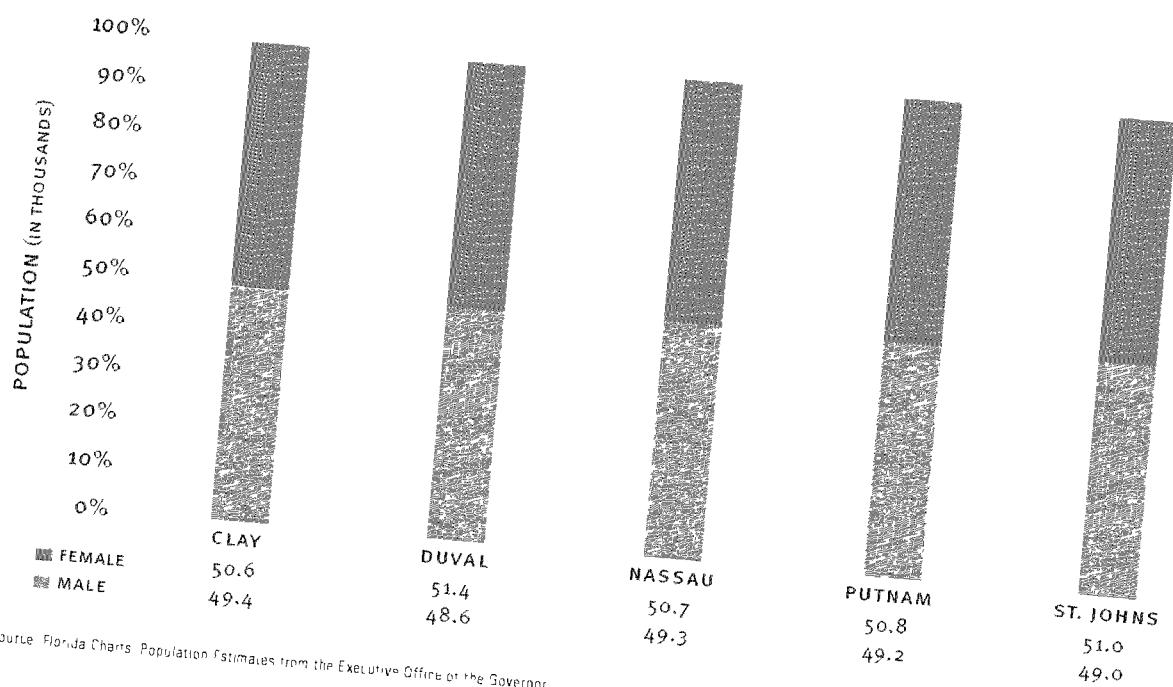
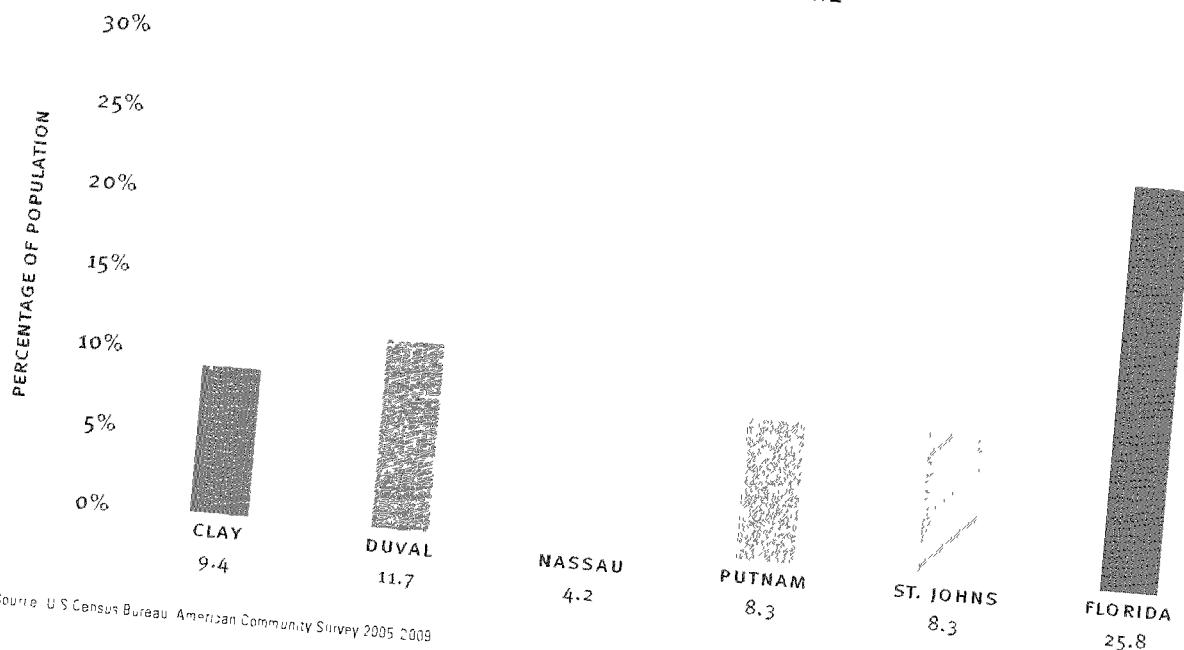


CHART 3-6 LANGUAGE OTHER THAN ENGLISH SPOKEN AT HOME



ECONOMIC CONDITIONS

The economic downturn clearly had an effect on the economics of the region, as it did throughout the nation. Poverty increased, as did unemployment.

Income

Median household incomes in Clay, Nassau and St. Johns Counties are all around \$60,000. Putnam County has the lowest median family income at \$33,842 and is the only county with a median family income below the state average (\$44,409). There are stark differences in median family income between Black and White residents in all counties except for Clay (difference of less than \$4,000). See Chart 3-7 for median household income for all counties and by race.

Poverty

In 2010, nearly one in four residents of Putnam County (24.6 percent) lived in families with incomes below 100 percent of the Federal Poverty Guidelines (FPG). Additionally, more than one in three children in Putnam County (35.6 percent) live in poverty. Only Putnam County has percentages higher than the state level (12 percent for all families and 19.5 percent for children). Nassau County has the lowest family poverty rate in the assessment region at 8.0 percent, but Clay County has the lowest child poverty rate at 14 percent. See Chart 3-8 for county comparison of poverty rates for 2000 and 2010.

Employment

Unemployment rates have at least tripled for all five counties in the assessment region, as well as for the state of Florida since 2006. However, the growth of the unemployment rate has slowed. For five years, Putnam County has had the highest levels of unemployment and is the only county to consistently sit above the state average. In 2010, Putnam County's rate of 12.6 percent was followed by Duval at 11.7 percent. St. Johns County had the lowest unemployment rate at 9.5 percent. See Chart 3-9 for average annual unemployment rates from 2006 to 2010.

Focus group respondents were divided on the topic of economic opportunity. While some felt there was little to no opportunity, others felt that the city's colleges, hospitals and the port provide opportunities for residents. Additionally, the loss of employment in the area has led to subsequent loss of health insurance. Even those who have kept their jobs have seen an increase in premiums and co-pays.

Housing

Clay, Nassau and St. Johns Counties have homeownership rates of about 78 percent. Duval County is the only county in the assessment region with a homeownership rate lower than the state level. See Chart 3-10 for homeownership rates in all five counties and Florida. In all five counties, most residents spend 35 percent or more of their household income on rent. This level is highest in Putnam County and lowest in Nassau County. See Chart 3-11 for a description of gross rent as a percentage of household income by county.



Homelessness

The number of individuals who meet the federal definition for homelessness has increased in Duval County since 2008, while Putnam County has seen a decrease, and St. Johns County has stayed almost exactly the same. See Chart 3-12 for trends in all five counties. When considering the state of Florida's homeless definition, Duval County has the highest numbers. There is no data available for Putnam and St. Johns Counties. See Chart 3-13 for more information. The demographics of the homeless population in Duval, Clay and Nassau Counties are as follows:

- 91 percent of the individuals are between the ages of 18 and 60 years old
- 71 percent are male
- 57 percent are Black



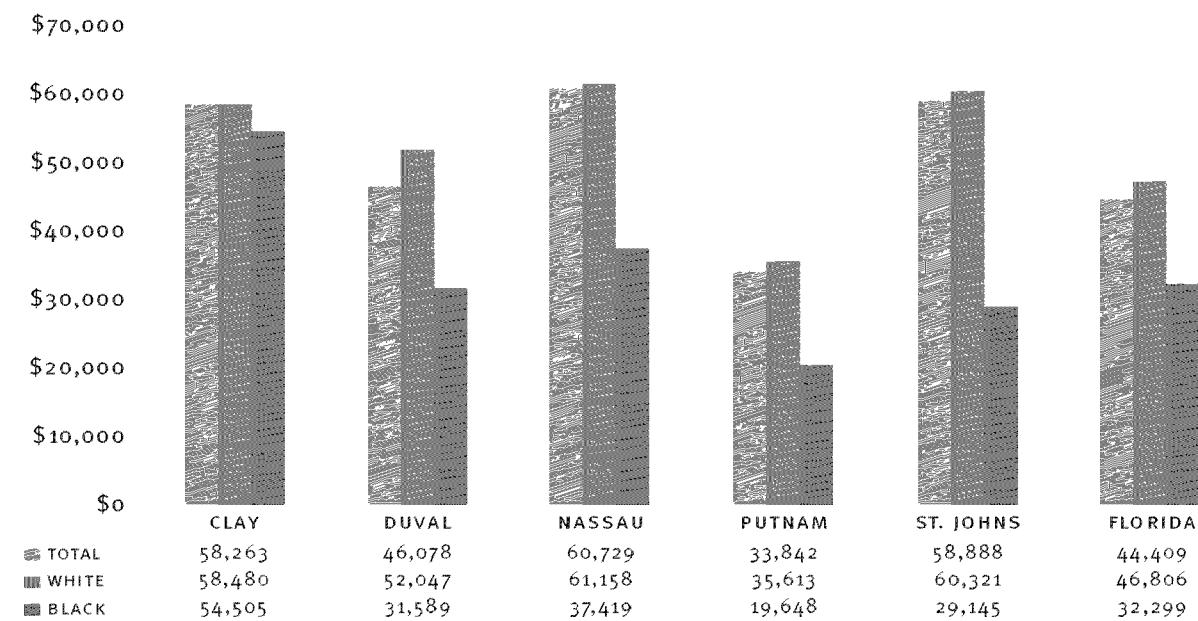
See Table 3-1 for characteristics of the homeless population.

Key Findings

- Poverty and unemployment increased from 2000 to 2010.
- Putnam County has very high poverty rates, both for families and children, as well as the highest unemployment rates for the past five years.
- In all five counties, unemployment is rising, but it is rising slower than over the past five years.
- Unemployment is lowest in St. Johns County.
- Most residents in the assessment region spend more than 35 percent of their income on rent.
- Duval County has the highest number of homeless individuals.

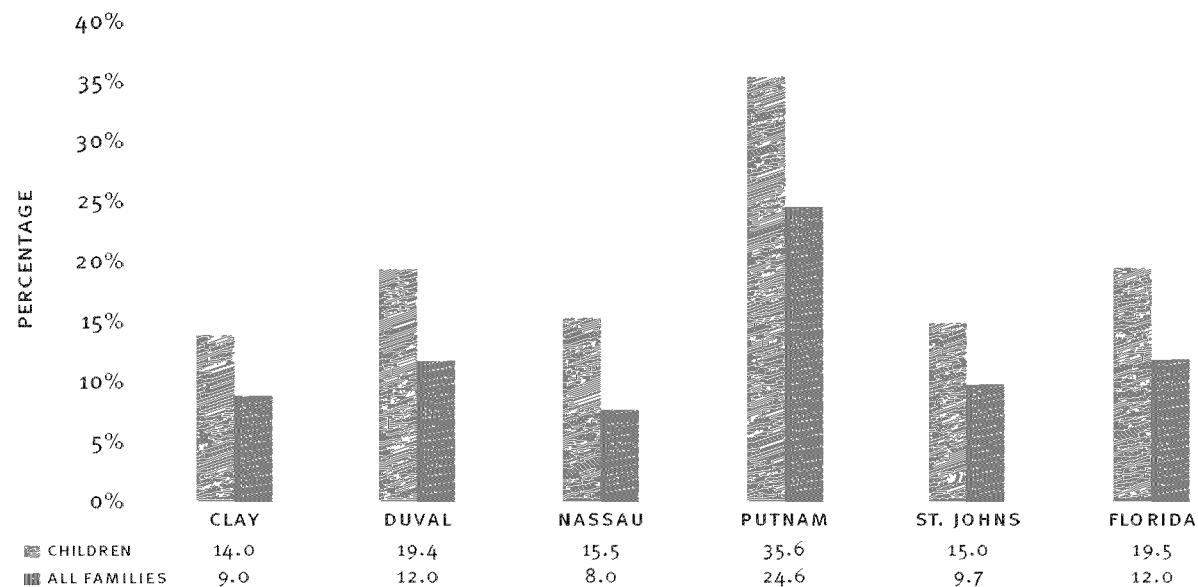


CHART 3-7



Source: U.S. Census Bureau - 2010 American Community Survey

CHART 3-8



Source: U.S. Census Bureau - 2010 American Community Survey

CHART 3-9

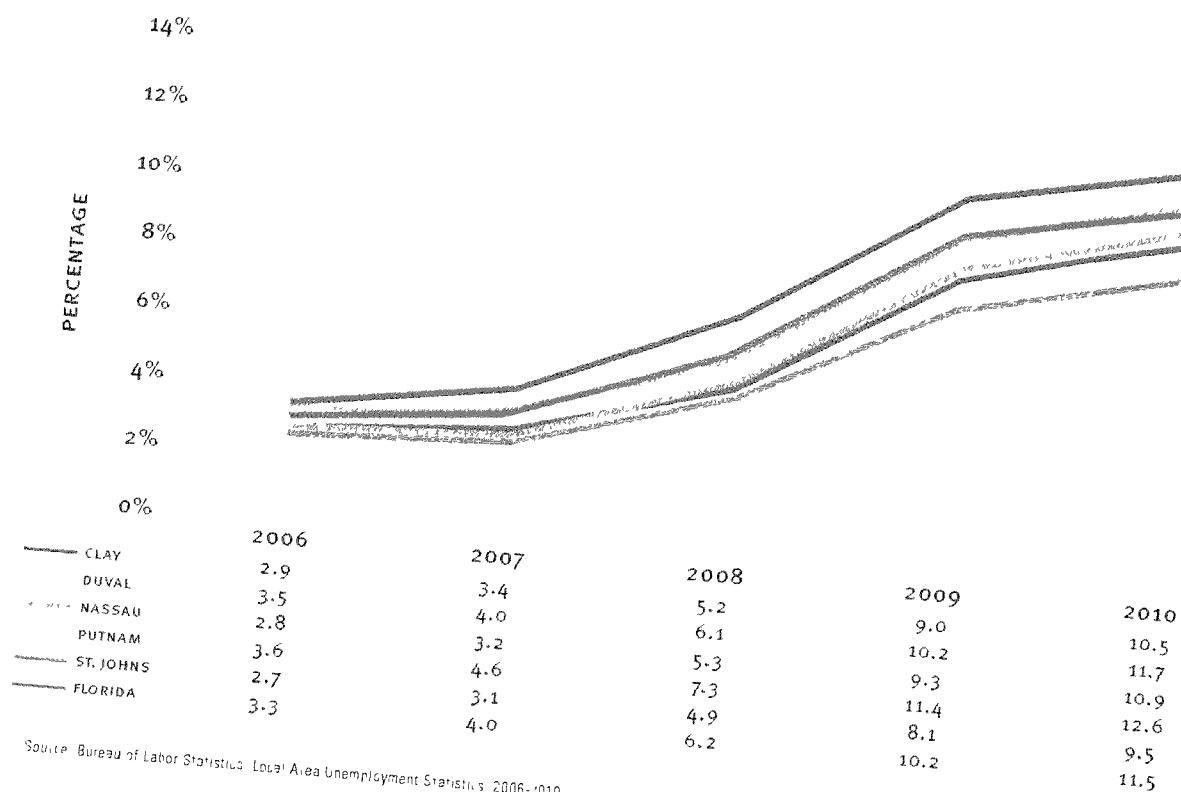


CHART 3-10 HOME OWNERSHIP RATES

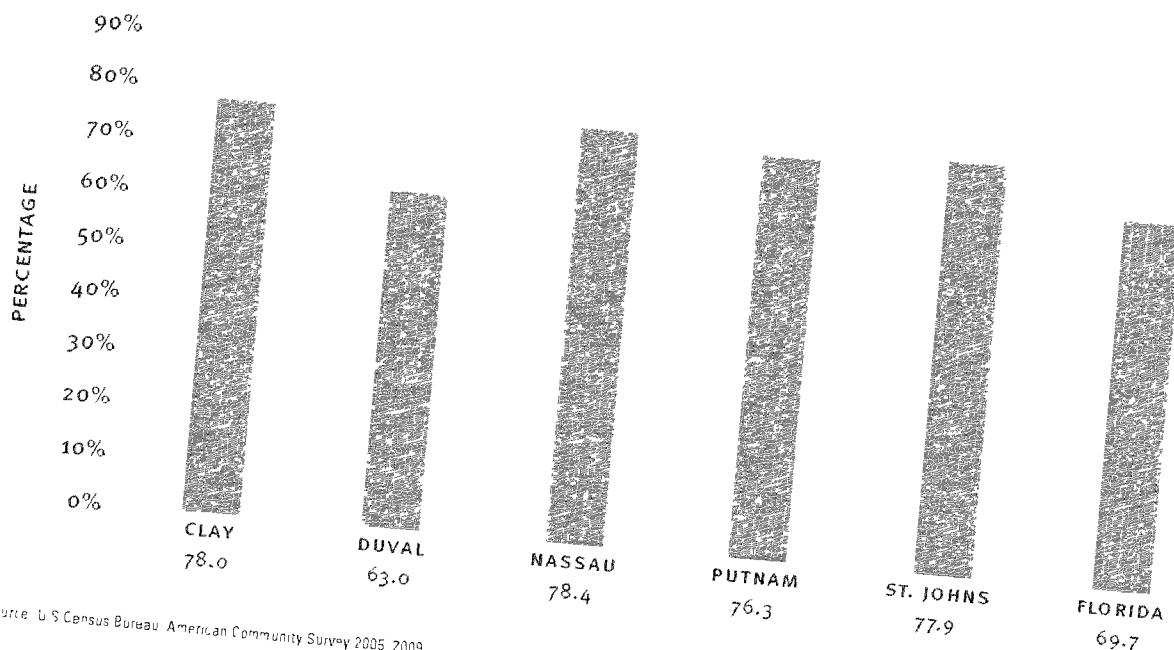
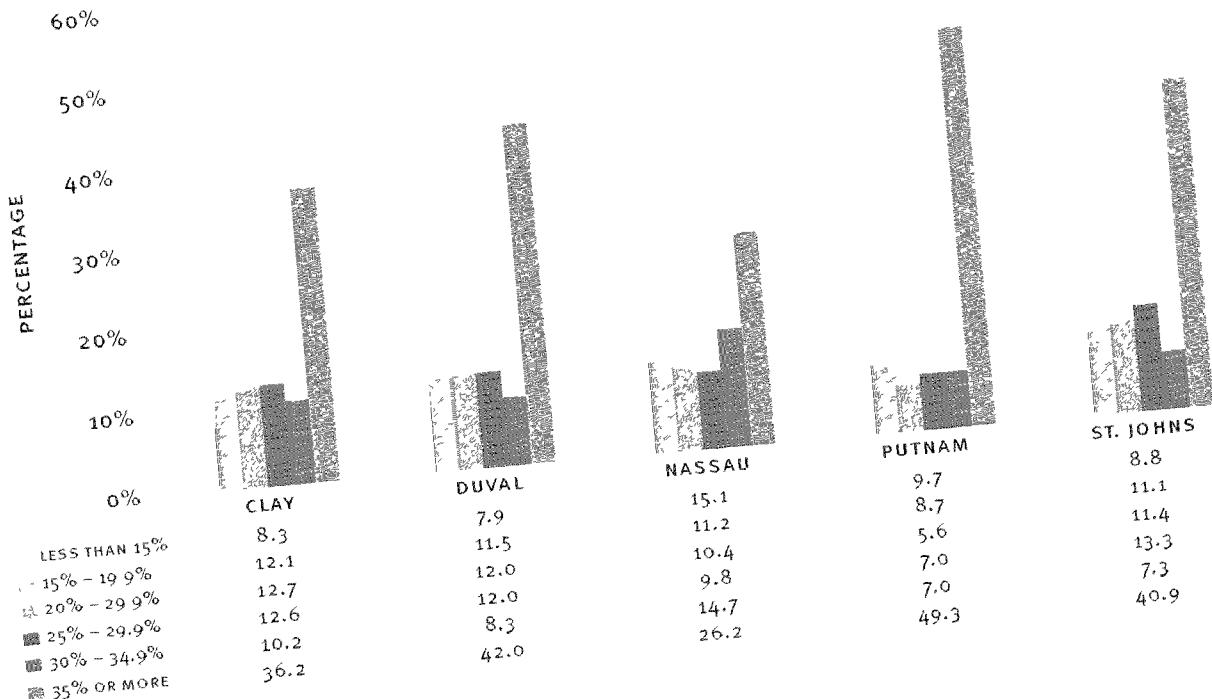
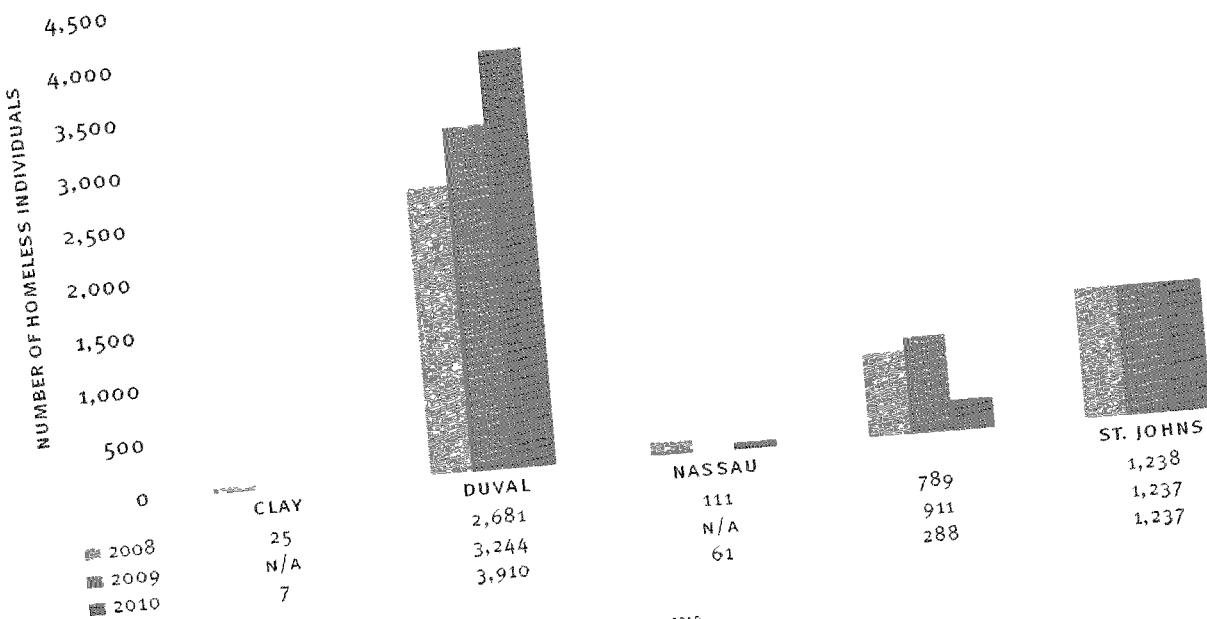


CHART 3-11 GROSS AS A PERCENT OF HOUSEHOLD INCOME



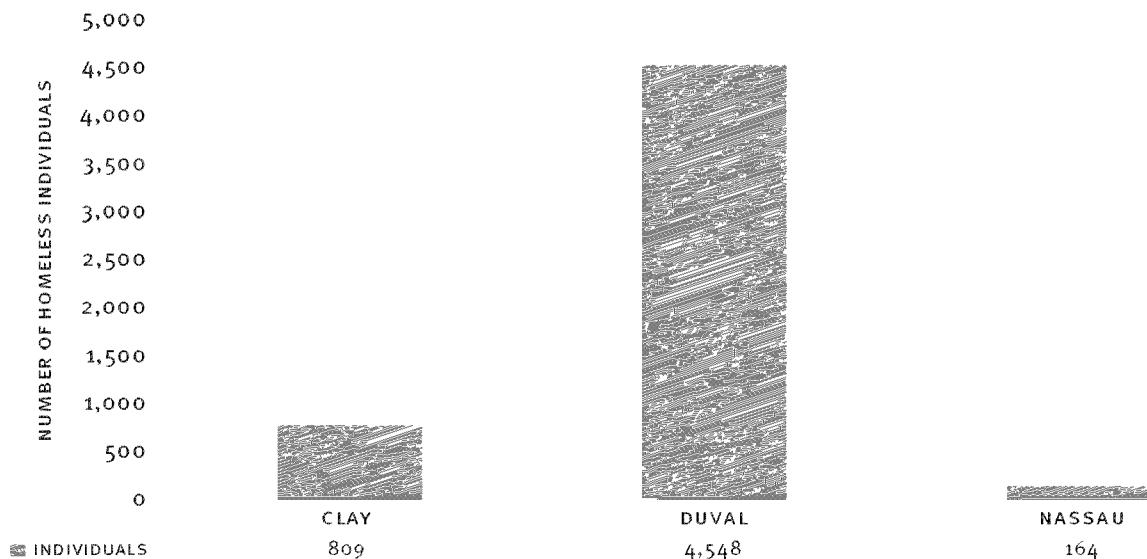
Source: U.S. Census Bureau 2010

CHART 3-12 FEDERAL HOMELESS DEFINITION



Source: Department of Children and Families, Annual Report on Homeless Conditions in Florida 2010

CHART 3-13



Source: Department of Children and Families Annual Report on Homeless Conditions in Florida 2010

TABLE 3-1

AGE			GENDER		RACE/ETHNICITY		
< 18 YEARS	18 - 60 YEARS	> 60 YEARS	MALE	FEMALE	WHITE	BLACK	HISPANIC
3%	91%	5%	71%	29%	39%	57%	4%

Source: Department of Children and Families Annual Report on Homeless Conditions in Florida 2010

SCHOOL AND STUDENT POPULATION

Focus group participants are not very satisfied with Duval County Public Schools and acknowledge that education affects health. They mentioned they feel that, in Duval County, private schools are a better choice for a quality education.

Student Race and Ethnicity

Only in Duval County are there more Black students than White. In the other four counties, White students make up at least 50 percent of the student population. There are the fewest numbers of minority students in Nassau and St. Johns Counties. The breakdown for the state of Florida is much more even than any of the counties in the assessment region. See Chart 3-14 for student race and ethnicity by county.



Graduation Rates

Nassau County has the highest graduation rate at 93.8 percent, followed by St. Johns County at 92.2 percent. Duval and Putnam Counties are below the state average of 80.1 percent. See Chart 3-15 for a comparison of graduation rates across counties.

School Absence

The percentage of students absent more than 21 days is highest in Putnam County (17.1 percent). The only other county above the state average is Duval County, which has the lowest rate at 5.9 percent. See Chart 3-16 to compare the absence rates across counties.

Homeless Students

During 2009-2010, Duval County had the highest number of homeless students (947) while Nassau County had the lowest (145). This kind of variation is expected with actual numbers, as counties with larger overall populations are likely to have higher actual numbers of homeless students. In Duval and Putnam Counties the number of homeless students decreased between 2005-2006 and 2009-2010. See Chart 3-17 for more information about homeless students in the assessment region.

Gang Activity

Based on students ages 15 to 17 witnessing delinquent behaviors among gang members at school, fighting is the most common behavior in Duval, Clay, Putnam and St. Johns Counties. In Nassau County, drug sales and carrying weapons were most frequently reported. See Chart 3-18 for more information on gang activity.

Key Findings

- White students make up more than 50 percent of the student body in all counties except for Duval, where there are more Black students than White.
- Nassau and St. Johns Counties have the highest graduation rates.

CHART 3-14

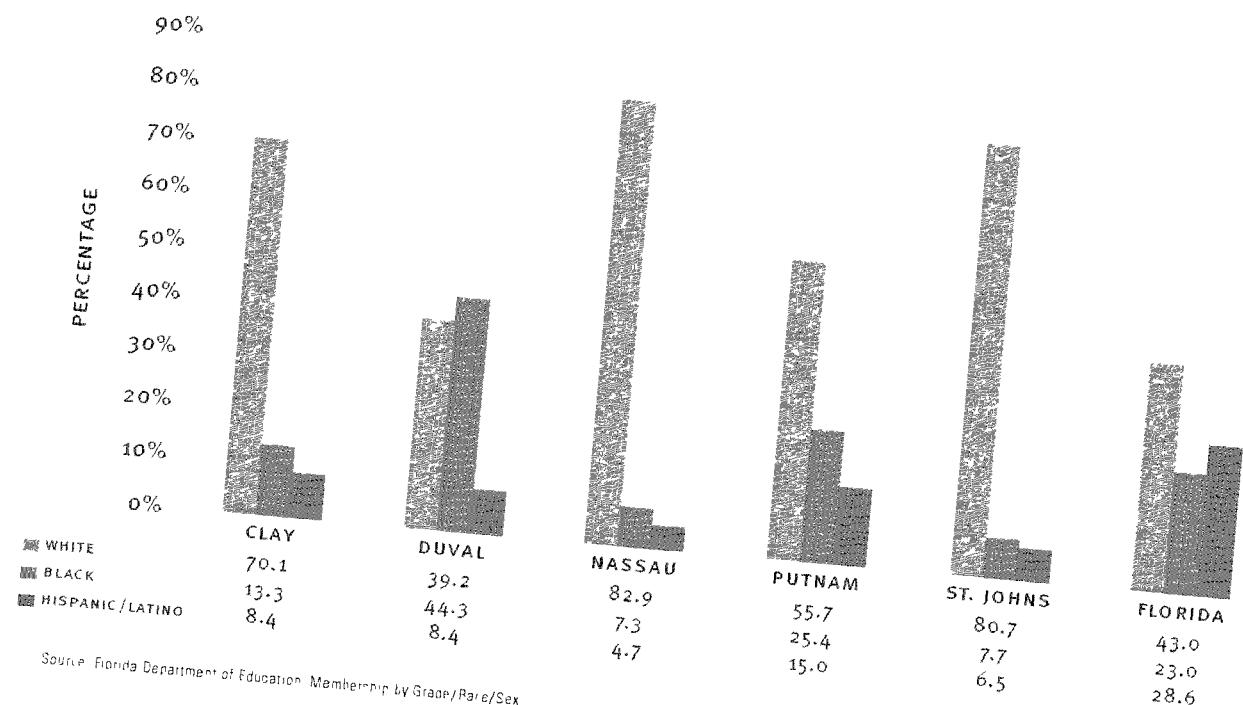


CHART 3-15

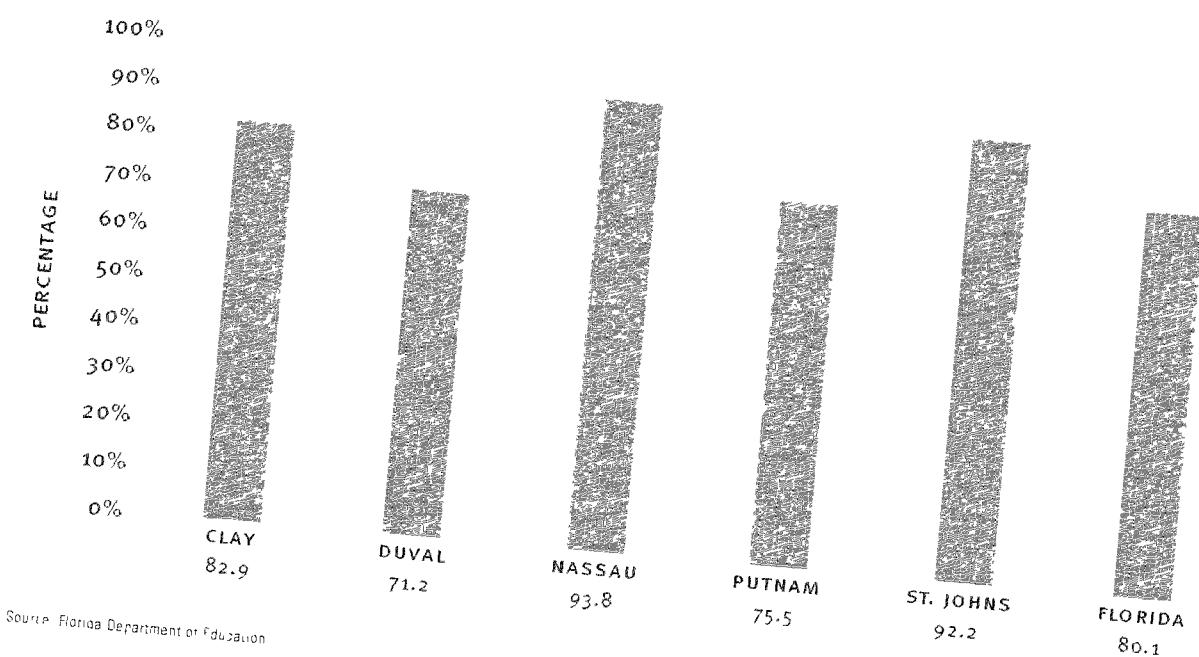
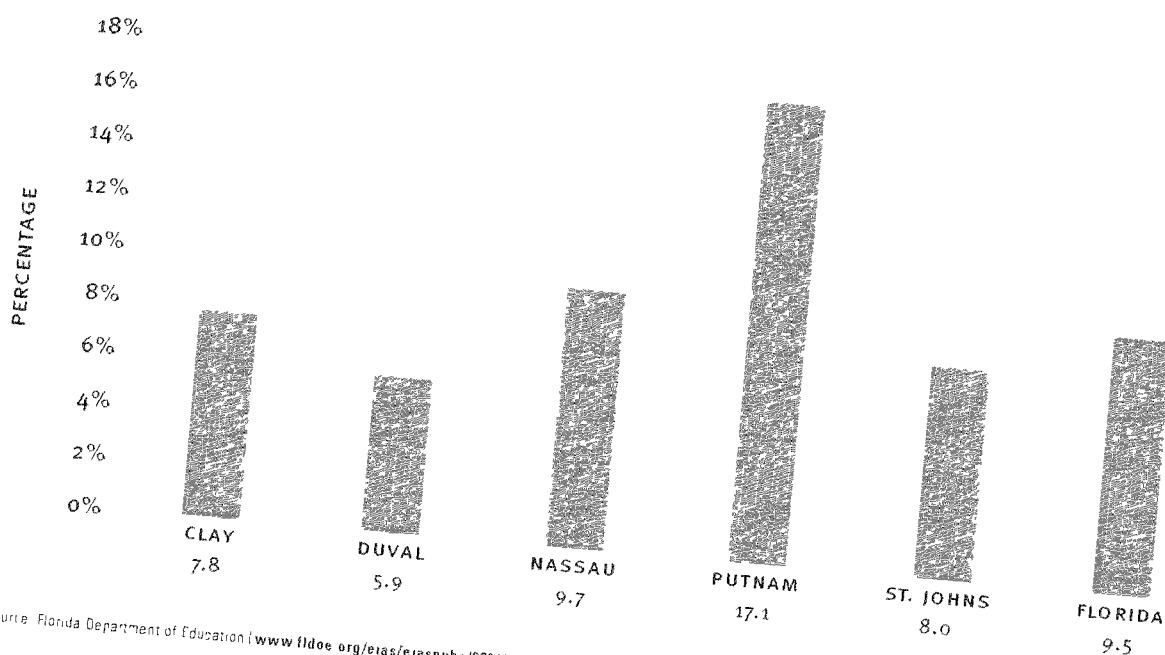
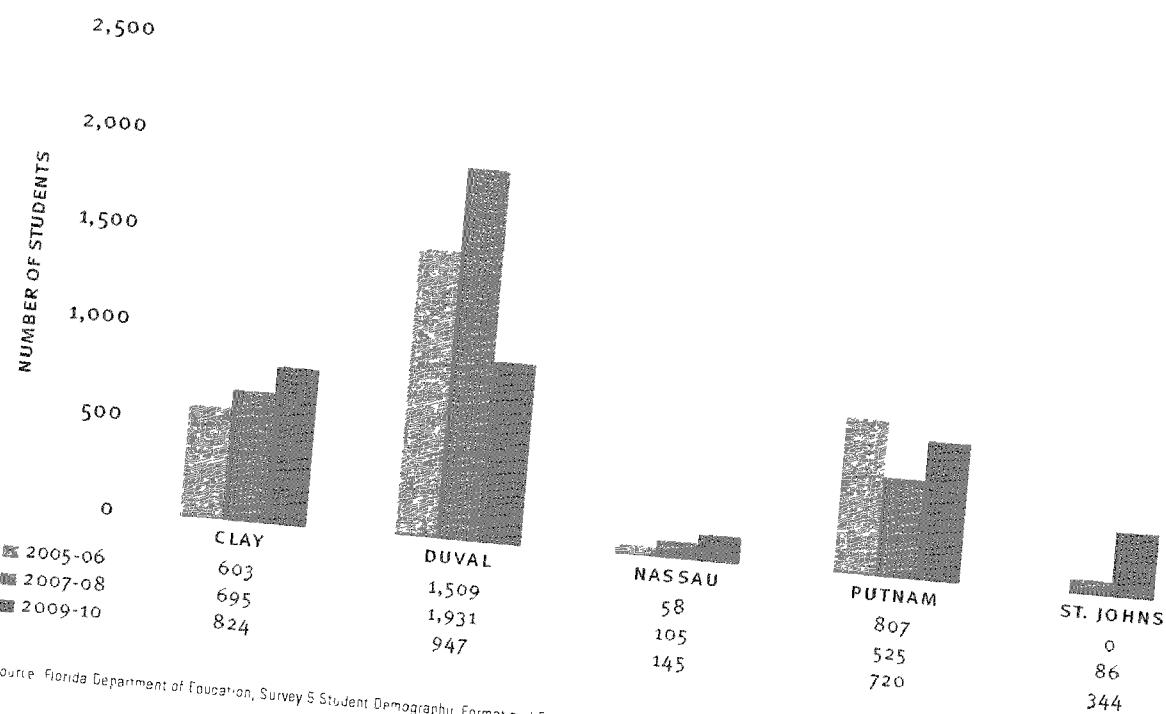


CHART 3-16 SCHOOL ABSENCE



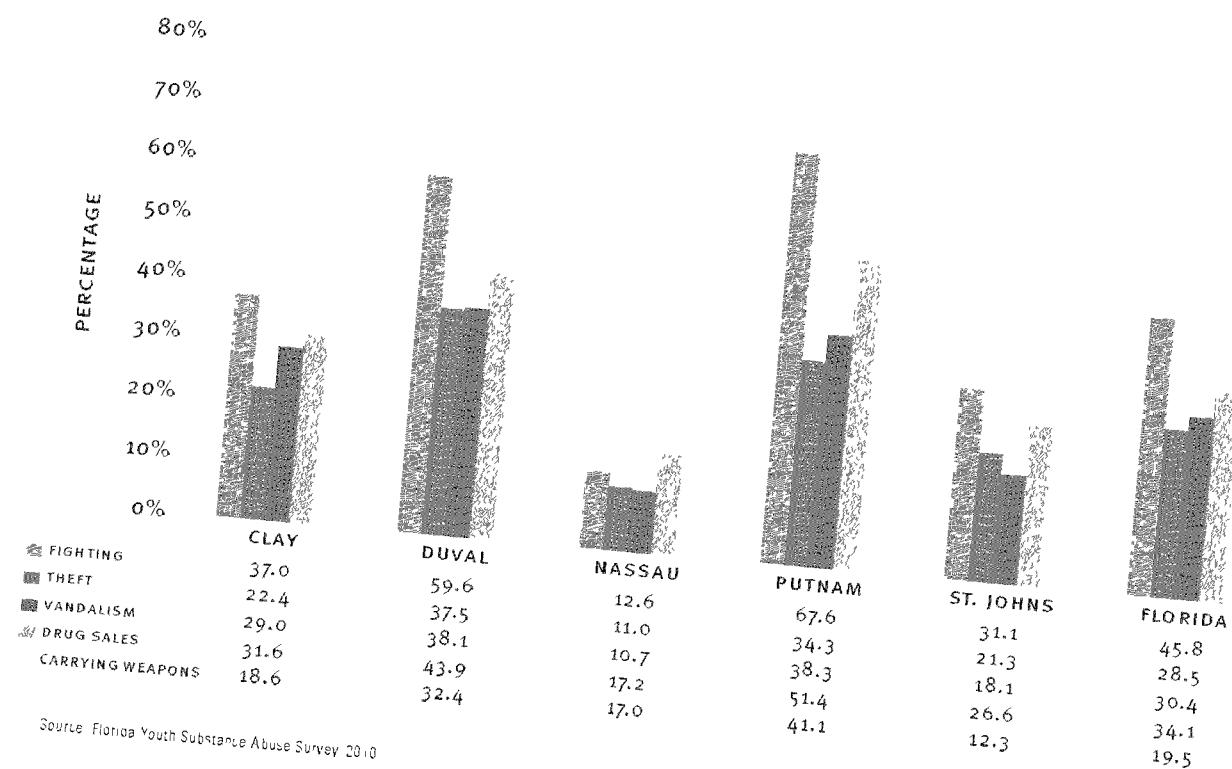
Source: Florida Department of Education (www.fldoe.org/eras/eraspubs/0809tsr.asp)

CHART 3-17



Source: Florida Department of Education, Survey 5 Student Demographic Form and Federal State Indicator Form

CHART 3-18 GANG ACTIVITY



PUBLIC SAFETY / CRIME

Focus group participants feel safe in most areas of Duval County, but acknowledge that there are some high-crime pockets in which they do not feel safe. Many participants expressed concern about safety and security at public schools.

Unintentional Injury

2010 rates of unintentional injury were highest in Putnam County (86.9 per 100,000), a stark increase from the two years prior. In Duval County, the rate stayed around 40, and decreases were observed in Clay, Nassau and St. Johns Counties. The rate for the state also decreased. See Chart 3-19 for a comparison of rates across counties from 2008 to 2010. Chart 3-20 illustrates the trends in unintentional drowning rates in every county of the assessment region. The rate has changed very little in Clay and Duval Counties, as well as the state of Florida. The rates in Nassau and St. Johns Counties have been approximately cut in half, while Putnam County rates have more than doubled.

Motor Vehicle Crash

Motor vehicle crashes have steadily declined in all five counties of the assessment region, as well as in the state of Florida. The 2010 rate for Putnam County was the highest in the region at 36.5 per 100,000, while St. Johns County had the lowest at 8.3. Duval, Clay and St. Johns Counties had rates below the state average of 12.6. See Chart 3-21 for a comparison of rates across counties from 2008 to 2010.

Domestic Violence

Domestic violence rates vary greatly by county. Over the last three years, rates have increased in Putnam, Duval and Nassau Counties. Clay County rates have declined, while St. Johns County and the Florida average have stayed about the same. The 2010 rate for Putnam County is the highest in the assessment region and more than double the Florida average. St. Johns County rates are the lowest (364.5 per 100,000). See Chart 3-22 for a comparison of rates across counties from 2008 to 2010.

Aggravated Assault

Rates of aggravated assault have dropped across the board. The most dramatic decline was in Nassau County, where the 2010 rate of 221.2 was down from 808.3 in 2008. Nassau County had the lowest rate, while Putnam County had the highest at 754.1. Putnam and Duval Counties have consistently had rates above the state average. See Chart 3-23 for details.

Forcible Sex Offenses

Rates of forcible sex offenses have declined in Clay, Nassau and St. Johns Counties since 2008. Putnam County rates have leveled off since 2009. Duval County is the only county in the assessment region to see an increase, and had the highest rate in 2010 at 78.3 per 100,000. The rates in Nassau and St. Johns Counties are well below the state average of 52.6. See Chart 3-24 for more information about forcible sex offense rates.

Homicide

Homicide rates have stayed about the same in all counties except for Putnam, where there was a drop from 11.0 to 7.7. Duval and Putnam Counties lie above the state average, and Duval County has the highest rate in the assessment region at 12.2 per 100,000. See Chart 3-25 for age-adjusted death rates per 100,000.

Charts 3-26 to 3-38 outline sports-related head injury data. Be sure to note the difference between Emergency Department (ED) visits and hospital admission data. Chart 3-26 shows that Duval County has the highest number of visits for patients with traumatic brain injury (TBI) at 2,410. However, St. Johns County has the highest proportion of those visits stemming from sports-related TBI (24.7 percent). Duval County saw the highest number of hospital admissions for patients with TBI (111).

In Chart 3-28, there is a noticeable increase in the number of ED visits in 2009. Additionally, 2009 saw the largest percentage of ED visits resulting from TBI, at 2.15 percent. In 2006 1.97 percent, in 2007 2.09 percent, and in 2008 1.85 percent. Chart 3-29 shows the noticeable decrease in the number of hospital admission visits in 2009. Additionally, 2009 saw the smallest percentage of hospital visits result from TBI, at 1.1 percent (in 2006 1.4 percent; in 2007 1.5 percent, and in 2008 1.2 percent).

From 2006 to 2009, sports-related TBIs accounted for 15 percent of all TBIs reported during this timeframe. There was a 75 percent increase in the number of children ages 10 to 18 years who went to the ED for treatment of a sports-related TBI between 2006 and 2009 (from 154 to 269), but the overall number of TBI for this period also increased (see Chart 3-30). Chart 3-31 outlines hospital admissions for TBI, both sports-related and non-sports-related. From 2006 to 2009, TBI hospital admissions dropped by 15. The percentage of those patients who had sports-related TBI increased slightly over the same timeframe (2006 5.1; 2009 5.5). Additionally, 2007 saw the highest number of admissions (99) and the highest percentage of sports-related TBI admissions (10.1 percent) from 2006 to 2009.

⁵ Data on sports related head injuries include all five counties in the assessment region.

Charts 3-32 and 3-33 and Tables 3-3 and 3-4 break the data down by age. The number of ED visits from 2006 to 2009 for patients with TBI increases steadily with age. However, the percentages of those visits that are sports-related do not follow this pattern. Incidence of TBI hospital admissions increases overall with age. However, ages 12 and 14 have the highest proportion of sports-related TBI (15.8 percent and 15.4 percent, respectively). The numbers of sports-related TBI are very small, so these differences are somewhat irrelevant. When it comes to gender, males make many more ED visits for TBI (see Chart 3-34). Additionally, the percentage of visits that are sports-related for males (17.8 percent) is higher than for females (8.8 percent). This disagrees with Covassin et al., their rate was higher in females. When the data is separated by race (Charts 3-36 and 3-37), White residents' ED visits with TBI are double that of Black and Other residents' combined, but they have the

14.3 percent). Black 15.2 percent; Other 16.4 percent. White residents' hospital admissions with TBI are double that of Black and Other residents' combined. Black patients have the lowest proportion of sports-related TBI visits (6.2 percent). Other patients have a very high percentage (22.2 percent).

Tables 3-6 and 3-7 show which hospitals see TBI patients. Shands sees the highest volume of patients with TBI (1,045), but Baptist Medical Center South sees the highest percentage of sports-related TBI patients (32.8 percent). Shands has the highest volume of hospital admissions for patients with TBI (181) but Baptist Medical Center Jacksonville serves the highest percentage of sports-related TBI patients (23.8 percent). Rates for the other hospitals were too small to report. Chart 3-38 outlines the average length of stay (LOS). Across each year between 2006 through 2009, sports-related TBI resulted in shorter LOS than non-sports-related TBI. Both types of TBI have decreased in LOS from 2006 (sports-related -0.2, non-sports-related -0.3).

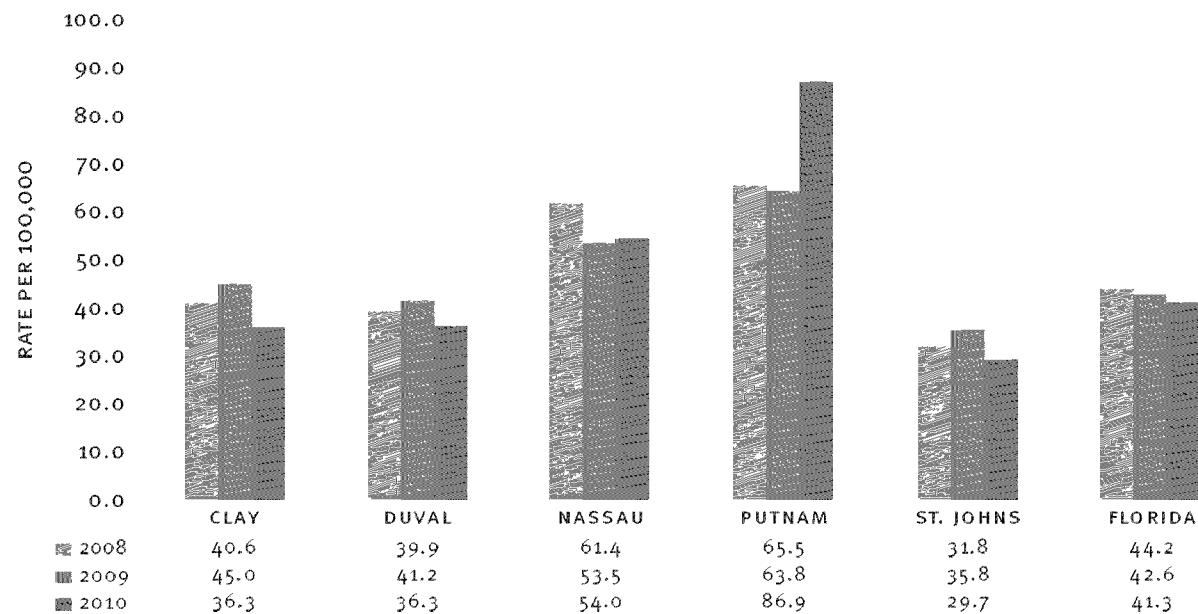
Juvenile Crime

Chart 3-39 shows the overall decline in juvenile arrests in the state of Florida since 1998. Table 3-8 provides self-reported data on violent behaviors both on and off school property. For all indicators, Duval County data was higher than the state level. County-level data was not available for the other counties of the assessment region. Thirty-two percent of students had been in a physical fight one or more times. Nearly 14 percent had been in a physical fight on school property. Nearly 19 percent had carried a weapon on at least one day, and 6.5 percent had done so on school property. See Table 3-8 for more data.

Key Findings

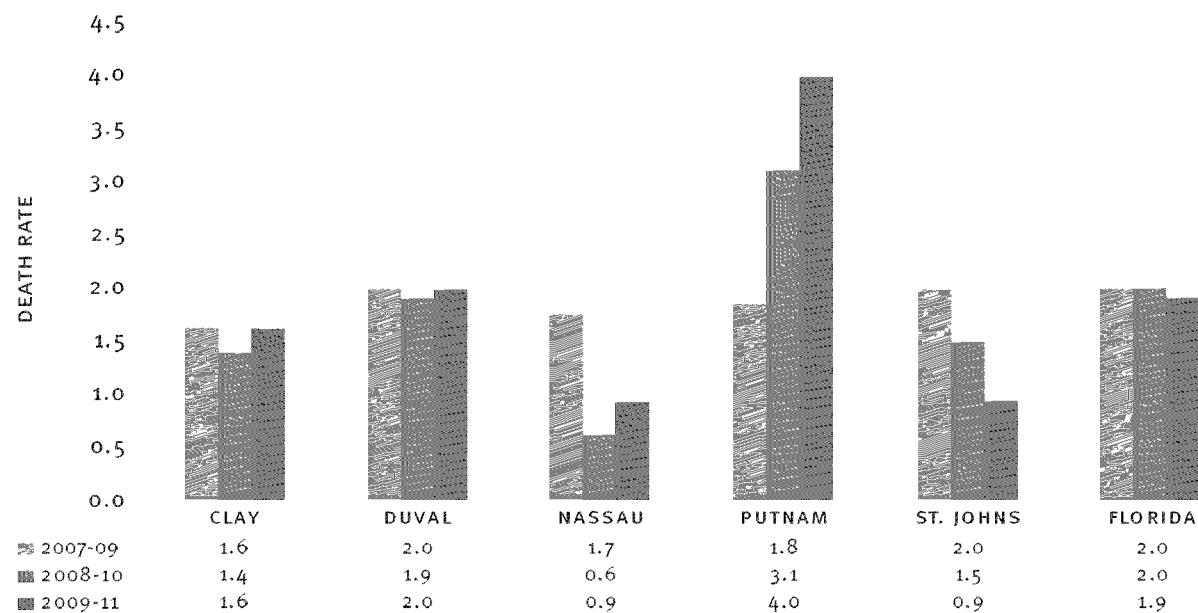
- Motor vehicle crashes have dropped in all of the counties in the region, as well as in the state
- Unintentional injury and drownings in Putnam County are significantly higher compared to the other four counties and the state average
- The rate of domestic violence in Putnam County is double that of the state average
- Rates of aggravated assault have dropped throughout the assessment region
- The rate of forcible sex offenses has increased in Duval County
- Homicide rates have stayed about the same, with the exception of a small drop in Putnam County
- Duval County has the highest number of visits for patients with TBI and St. Johns County has the highest proportion of those visits stemming from sports-related TBI
- Incidence of TBI hospital admissions increases overall with age. However, ages 12 and 14 have the highest proportion of sports-related TBI
- Males make many more ED visits for TBI
- Shands sees the highest volume of patients with TBI, but Baptist Medical Center South sees the highest percentage of sports-related TBI patients
- There has been an overall decline in juvenile arrests in the state of Florida, but for all indicators listed, Duval County percentages were higher than those at the state level

CHART 3-19



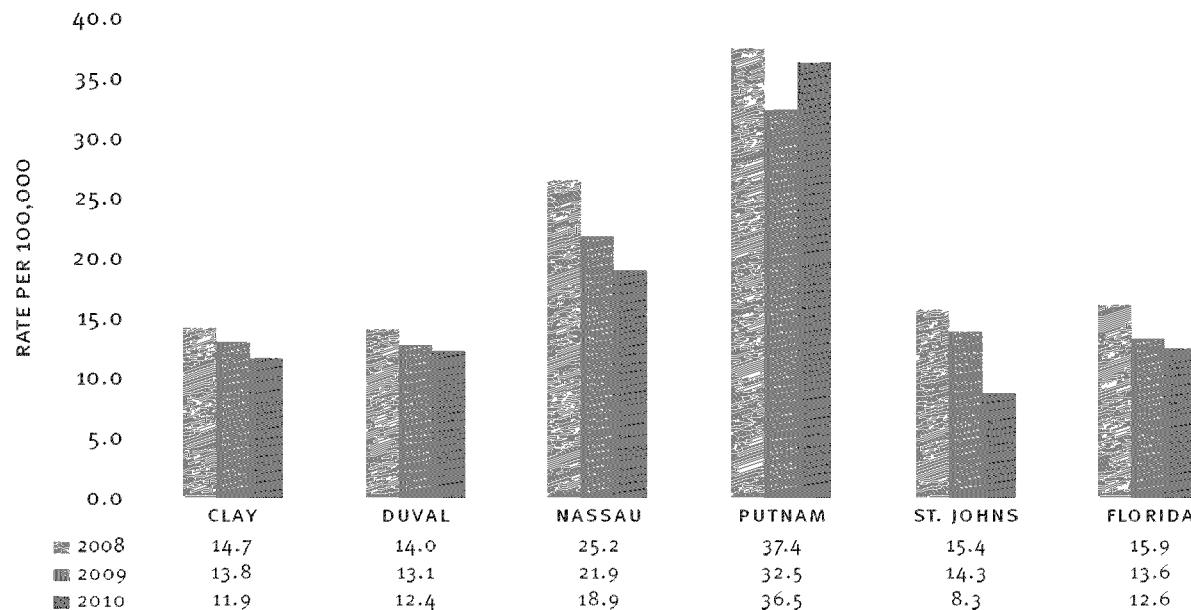
Source: Florida Department of Health Office of Health Statistics and Assessment

CHART 3-20 UNINTENTIONAL DROWNINGS



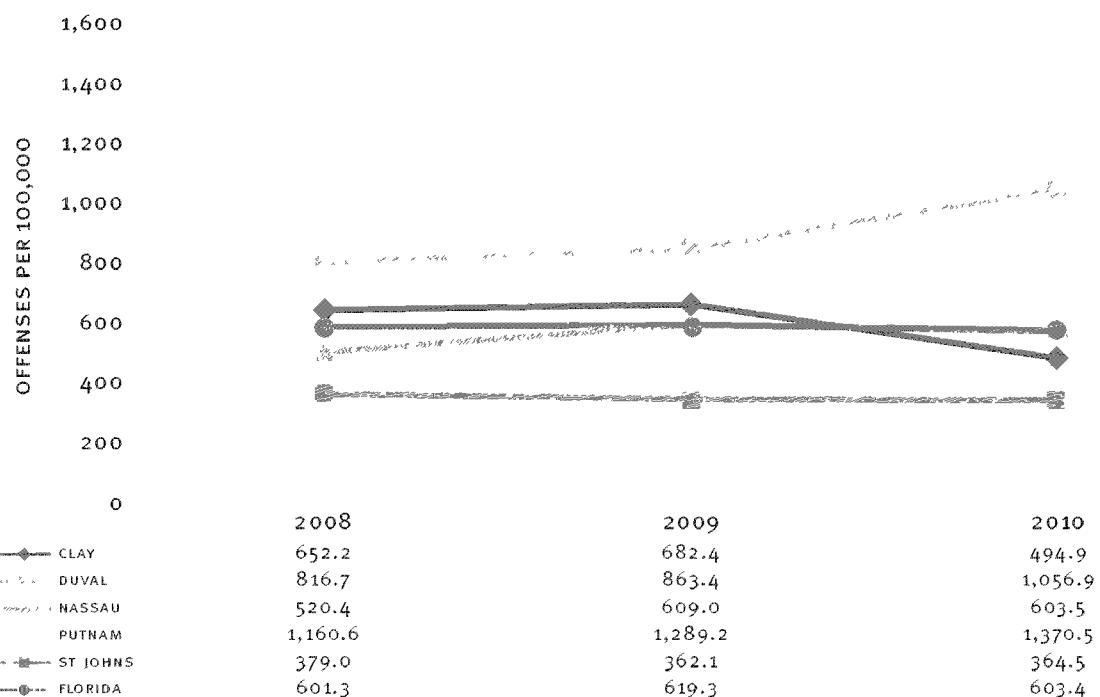
Source: Florida Department of Health Bureau of Vital Statistics

CHART 3-21



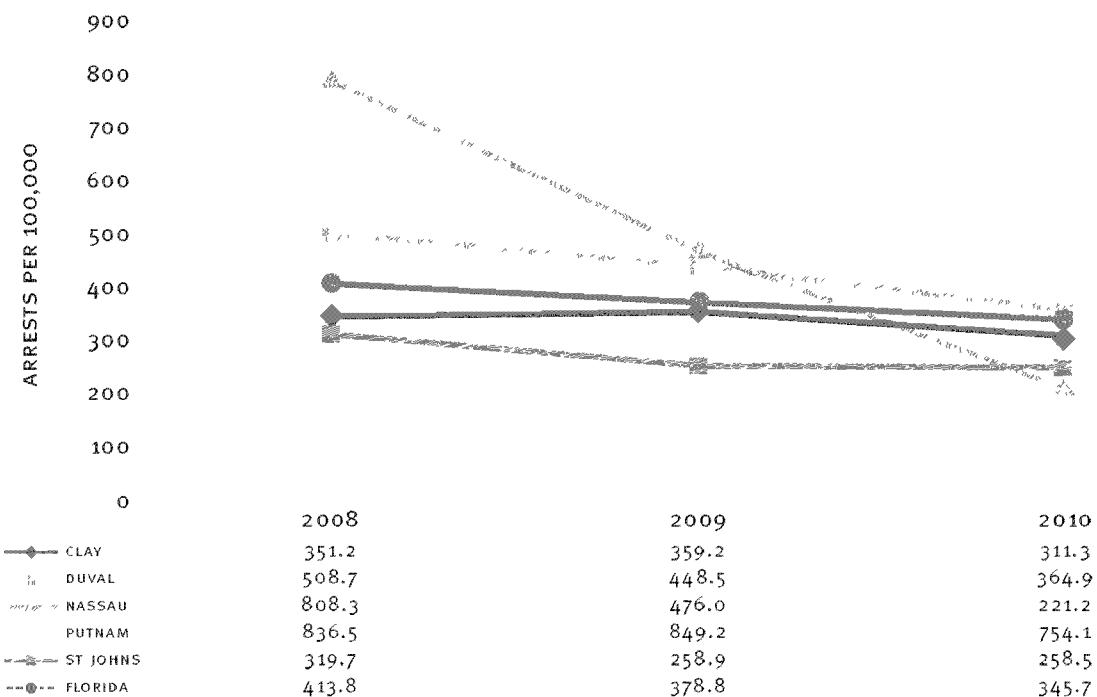
Source: Florida Department of Health Office of Health Statistics and Assessment

CHART 3-22



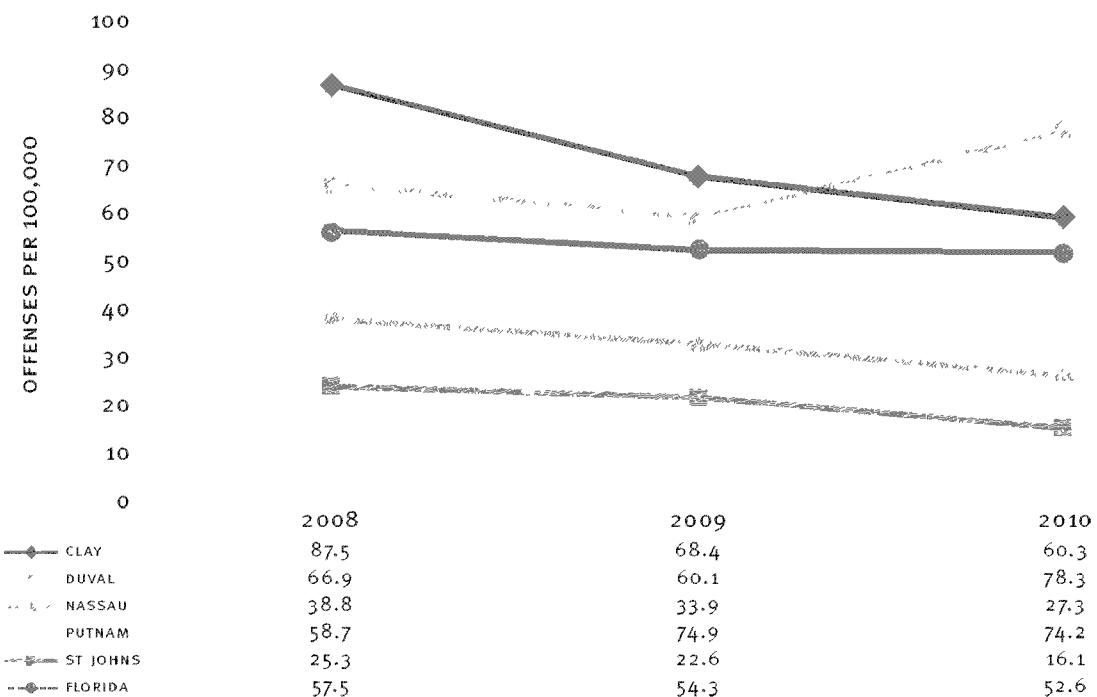
Source: Florida Department of Law Enforcement

CHART 3-23 AGGRAVATED ASSAULT



Source: Florida Department of Law Enforcement

CHART 3-24



Source: Florida Department of Law Enforcement

CHART 3-25 HOMICIDE

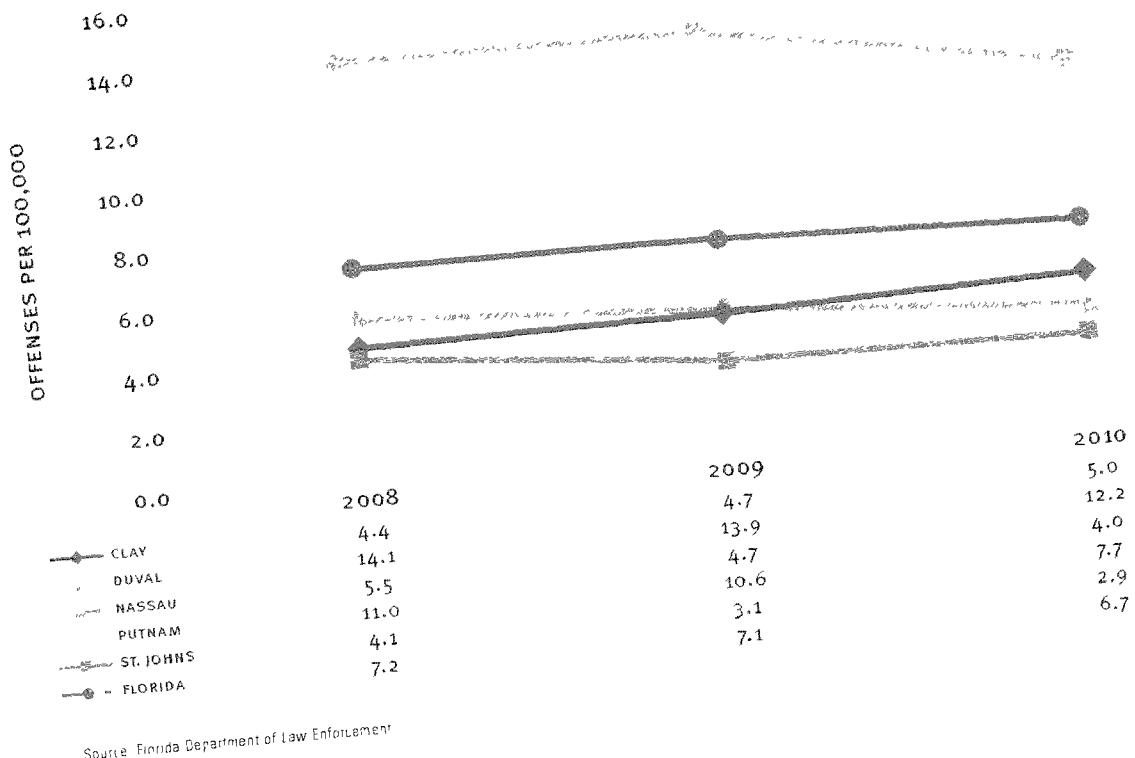
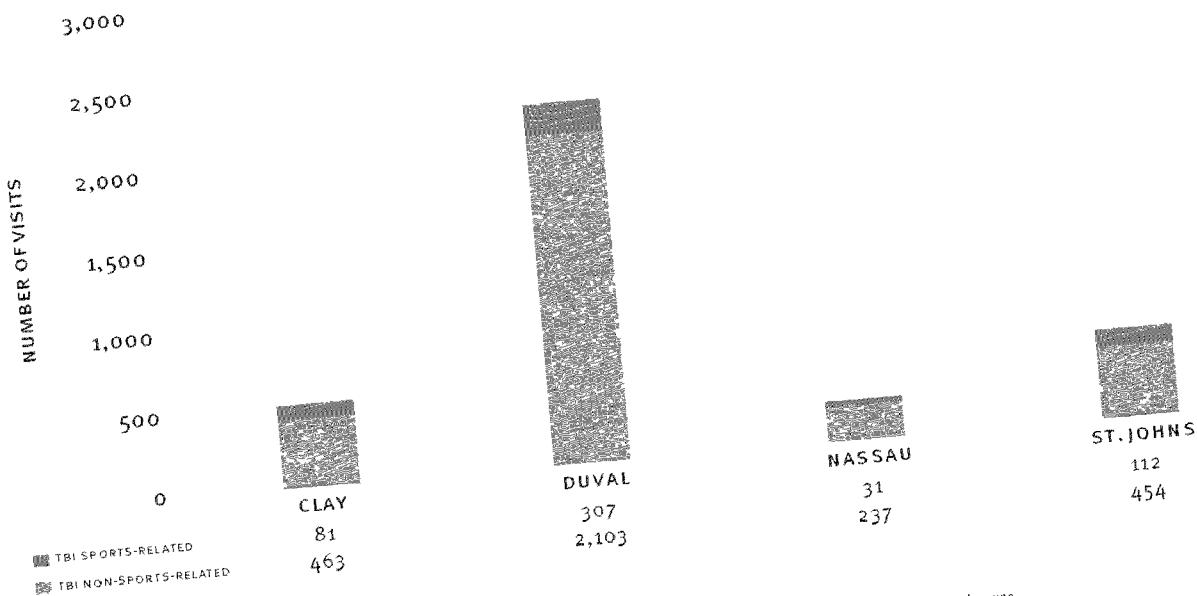
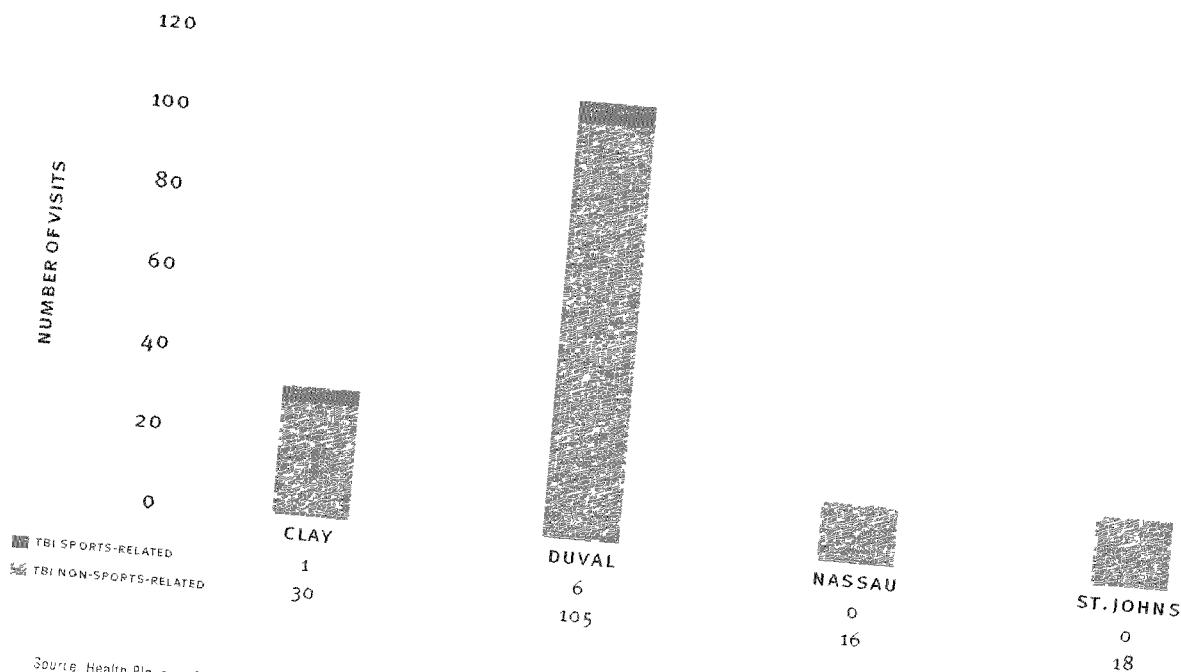


CHART 3-26 ED VISITS FOR PATIENTS WITH SPORTS-RELATED TBI VS. BY COUNTY

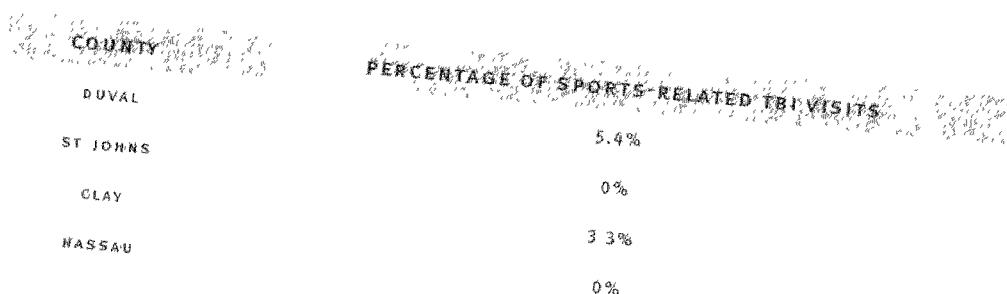


Source: Health Planning Council of Northeast Florida (2011) *EP and Hospital Admissions from Youth Sports Related Concussions or Head Injuries*

CHART 3-27 HOSPITAL ADMISSIONS FOR PATIENTS WITH SPORTS-RELATED TBI VS. NON-SPORTS-RELATED TBI, BY COUNTY

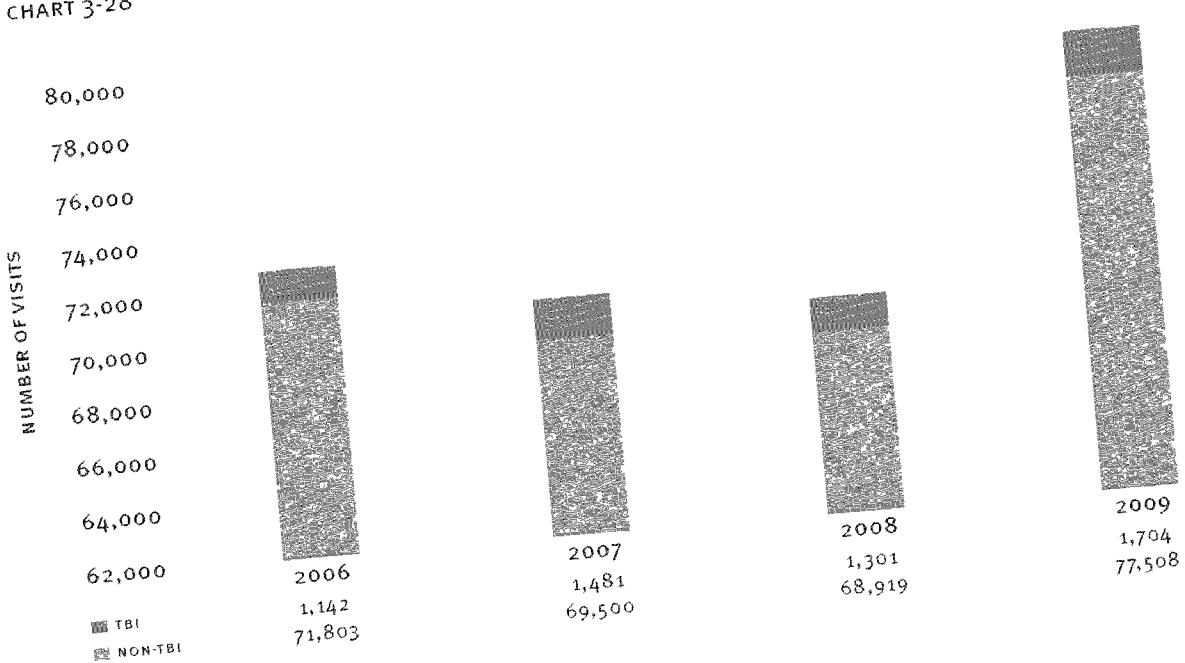


Source: Health Planning Council of Northeast Florida (2011) *ER and Hospital Admissions from Youth Sports Related Concussions or Head Injuries*



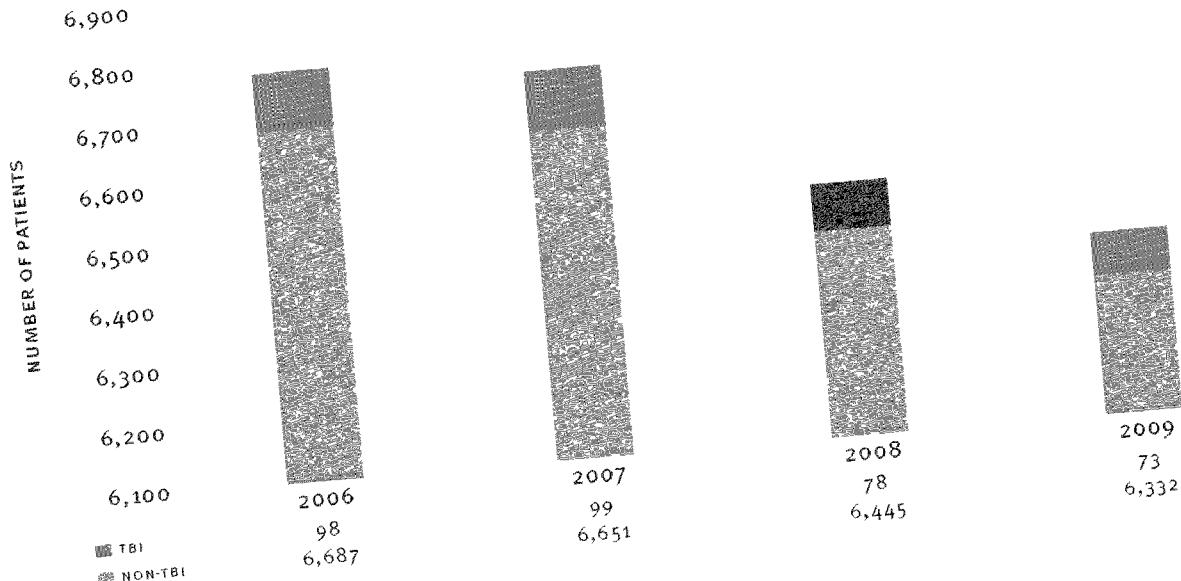
Source: Health Planning Council of Northeast Florida (2011) *ER and Hospital Admissions from Youth Sports Related Concussions or Head Injuries*

CHART 3-28



Source: Health Planning Council of Northeast Florida (2011) ER and Hospital Admissions from Youth Sports Related Concussions or Head Injuries

CHART 3-29 HOSPITAL ADMISSIONS FOR PATIENTS WITH TBI VS. NON-TBI

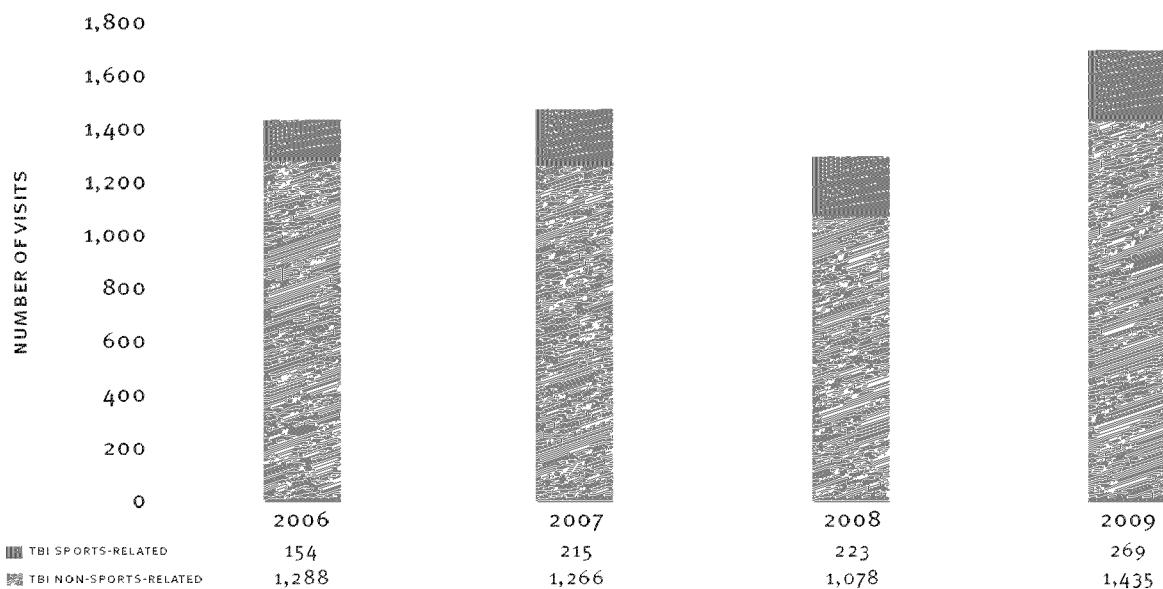


Source: Health Planning Council of Northeast Florida (2011) ER and Hospital Admissions from Youth Sports Related Concussions or Head Injuries

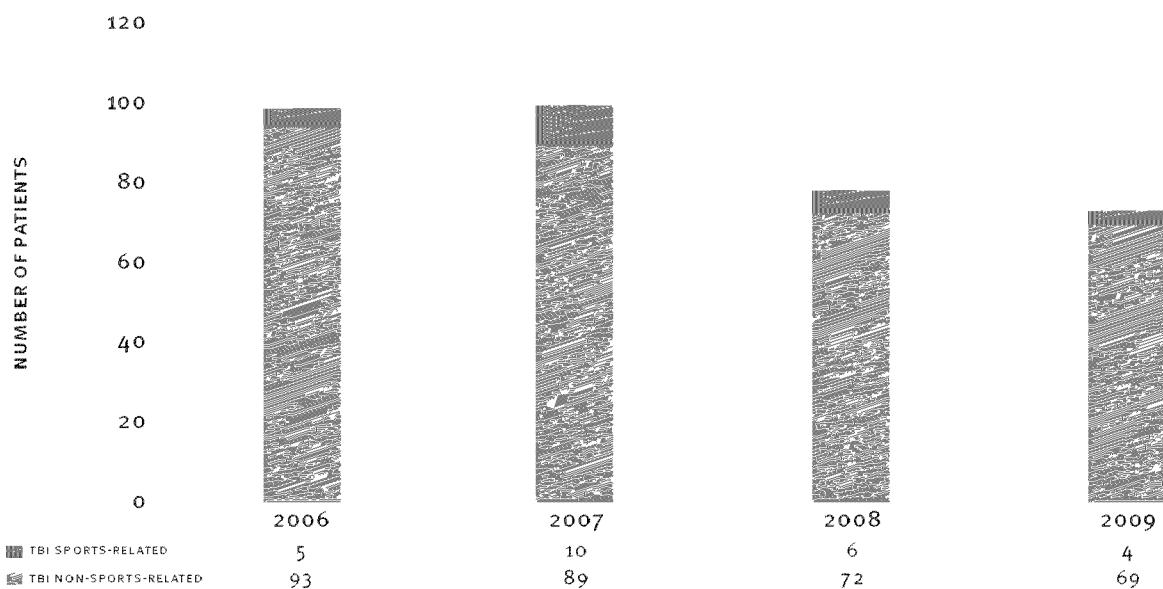
CHART 3-30

SPORTS-RELATED

VS. NON-SPORTS-RELATED



Source: Health Planning Council of Northeast Florida (2011) *ER and Hospital Admissions from Youth Sports Related Concussions or Head Injuries*

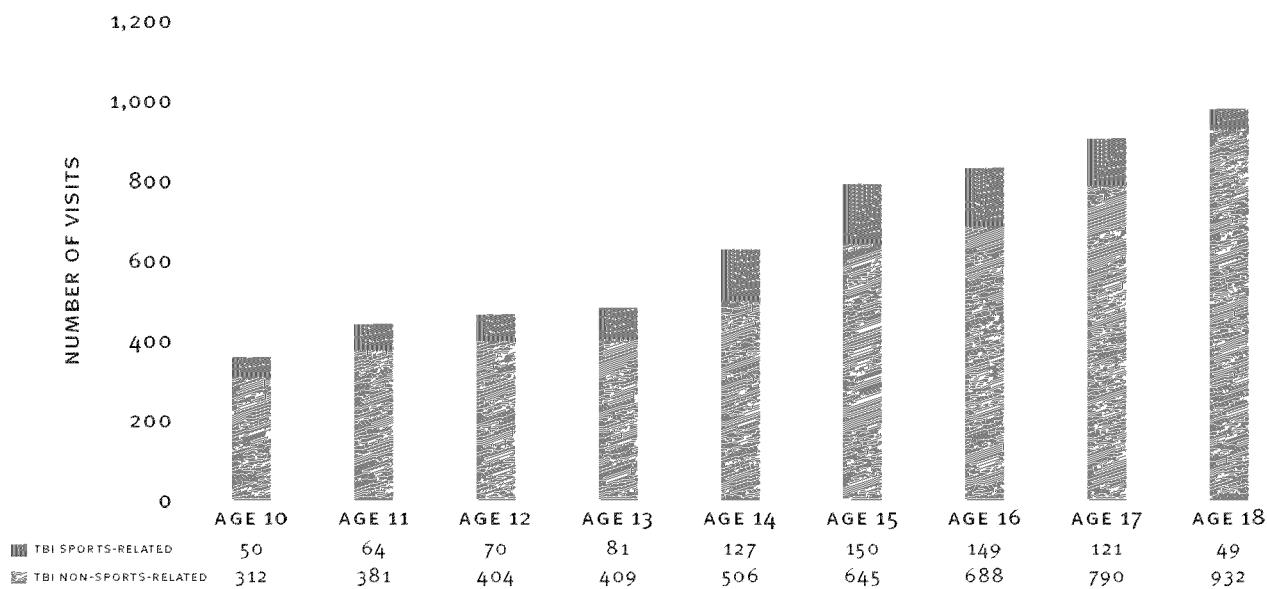
CHART 3-31 HOSPITAL ADMISSIONS FOR PATIENTS WITH TBI,
SPORTS-RELATED VS. NON-SPORTS-RELATED

Source: Health Planning Council of Northeast Florida (2011) *ER and Hospital Admissions from Youth Sports Related Concussions or Head Injuries*

CHART 3-32

SPORTS-RELATED AND

NON-SPORTS-RELATED, BY AGE



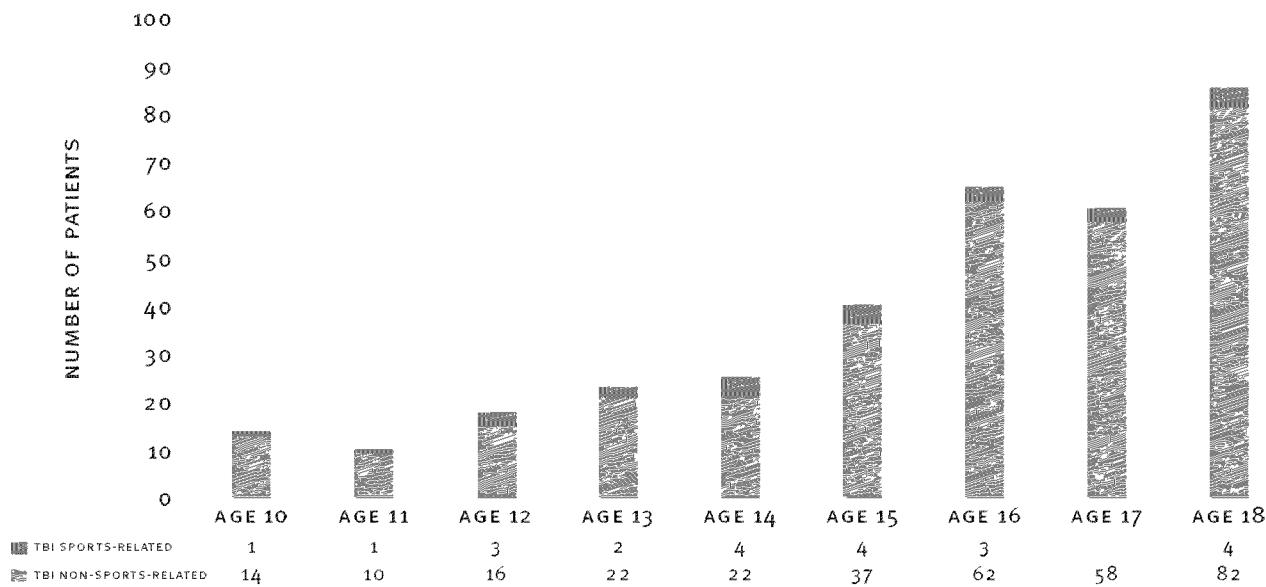
Source: Health Planning Council of Northeast Florida (2011) *ER and Hospital Admissions from Youth Sports Related Concussions or Head Injuries*

TABLE 3-3

AGE	PERCENTAGE OF TBI ED VISITS THAT ARE SPORTS-RELATED
10	13.8%
11	14.8%
12	14.8%
13	16.5%
14	13.8%
15	13.8%
16	13.3%
17	13.3%
18	5.0%

Source: Health Planning Council of Northeast Florida (2011) *ER and Hospital Admissions from Youth Sports Related Concussions or Head Injuries*

CHART 3-33 HOSPITAL ADMISSIONS FOR PATIENTS WITH TBI, SPORTS-RELATED AND NON-SPORTS-RELATED, BY AGE



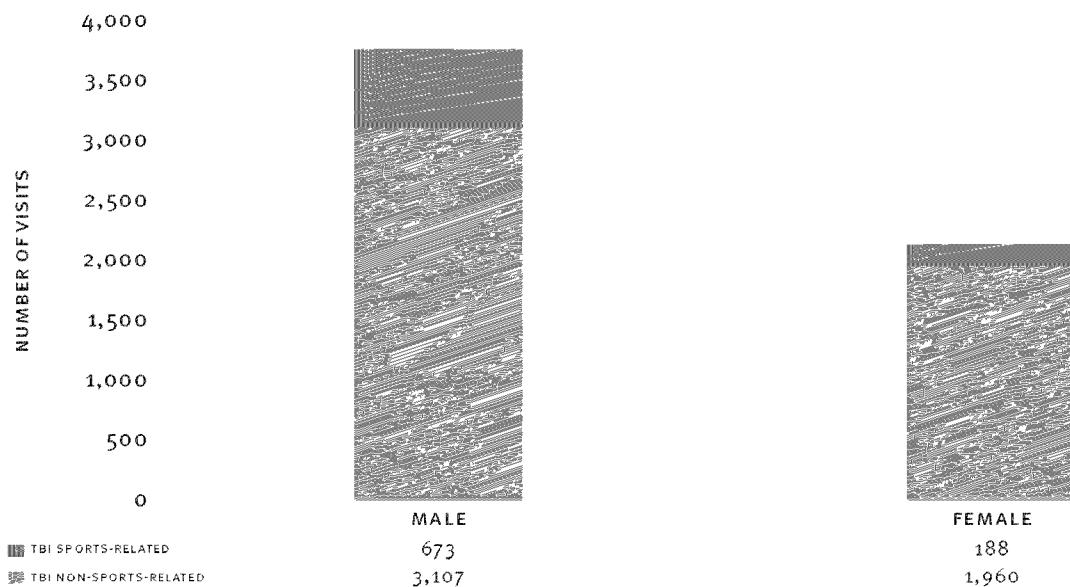
Source: Health Planning Council of Northeast Florida (2011) *ER and Hospital Admissions from Youth Sports Related Concussions or Head Injuries*

TABLE 3-4

AGE	PERCENTAGE OF TBI ADMISSIONS THAT ARE SPORTS-RELATED
10	6.7%
11	9.1%
12	15.8%
13	8.3%
14	15.4%
15	9.8%
16	4.6%
17	4.9%
18	1.2%

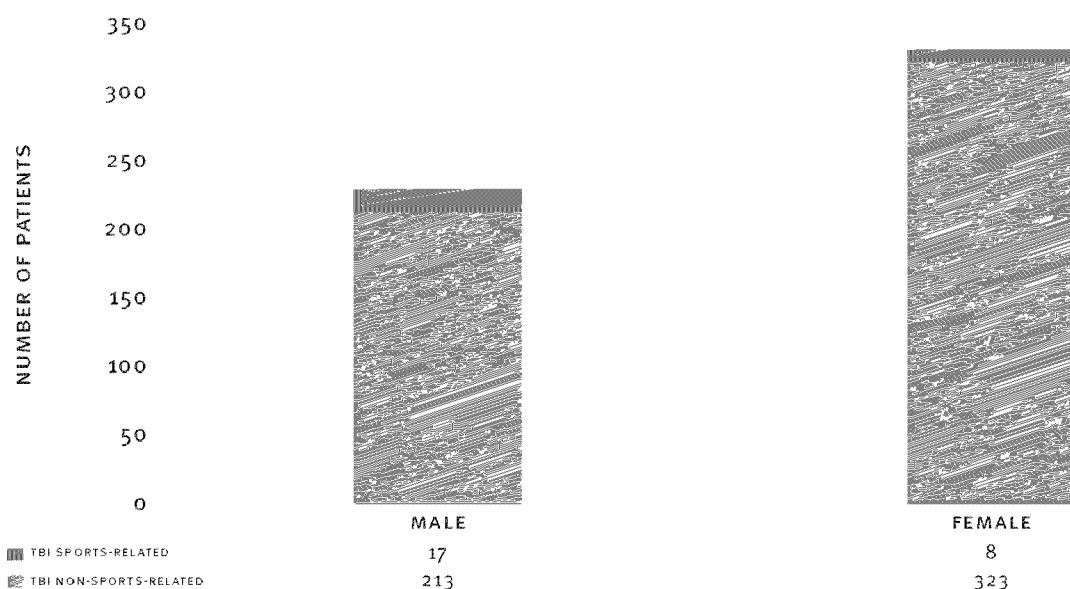
Source: Health Planning Council of Northeast Florida (2011) *ER and Hospital Admissions from Youth Sports Related Concussions or Head Injuries*

CHART 3-34 ED VISITS FOR PATIENTS WITH TBI, SPORTS-RELATED AND NON-SPORTS-RELATED,



Source: Health Planning Council of Northeast Florida (2011) *ER and Hospital Admissions from Youth Sports Related Concussions or Head Injuries*

CHART 3-35 FOR PATIENTS WITH TBI, SPORTS-RELATED AND NON-SPORTS-RELATED, BY GENDER



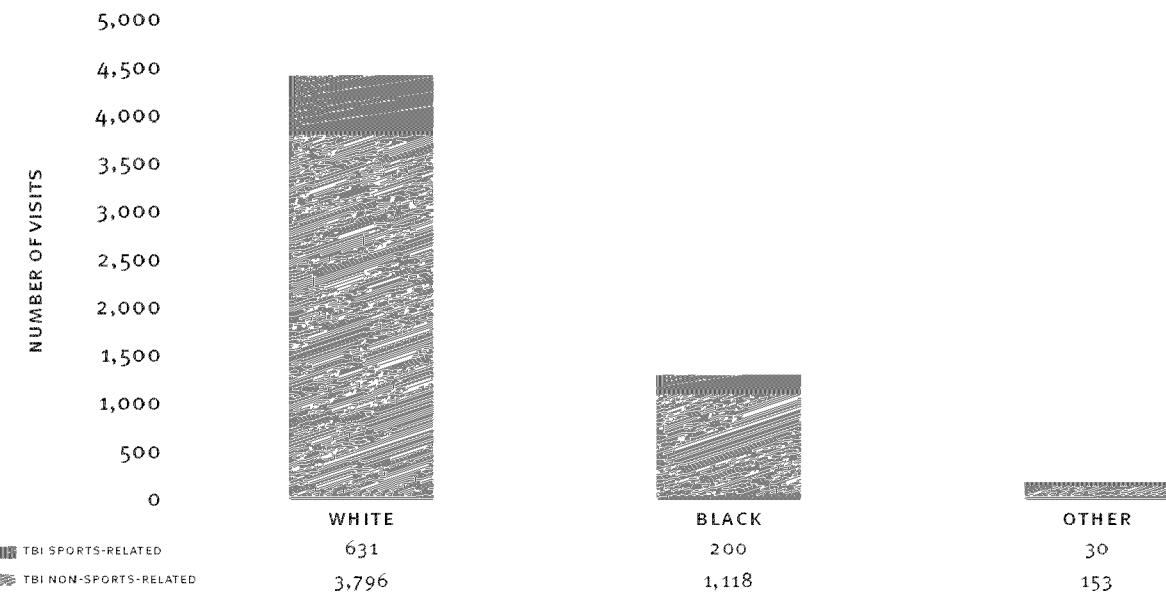
Source: Health Planning Council of Northeast Florida (2011) *ER and Hospital Admissions from Youth Sports Related Concussions or Head Injuries*

TABLE 3-5

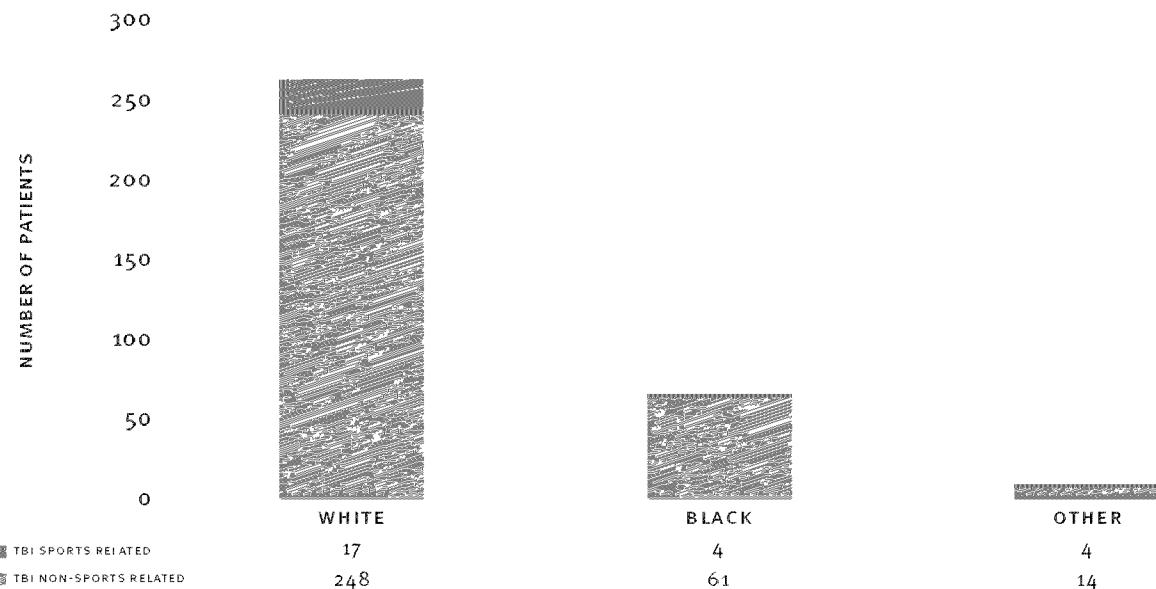
GENDER	ED VISITS FOR SPORTS-RELATED TBI	ED VISITS FOR NON-SPORTS-RELATED TBI	HOSPITALIZATION FOR SPORTS-RELATED TBI	HOSPITALIZATION FOR NON-SPORTS-RELATED TBI
	MALE	673	3,107	213
FEMALE	188	1,960	8	323

Source: Health Planning Council of Northeast Florida (2011) *ER and Hospital Admissions from Youth Sports Related Concussions or Head Injuries*

CHART 3-36 ED VISITS TBI, SPORTS-RELATED VS. NON-SPORTS-RELATED,



Source: Health Planning Council of Northeast Florida (2011) *ER and Hospital Admissions from Youth Sports Related Concussions or Head Injuries*

CHART 3-37 HOSPITAL ADMISSIONS FOR PATIENTS WITH TBI,
SPORTS-RELATED AND NON-SPORTS-RELATED,

Source: Health Planning Council of Northeast Florida (2011) *ER and Hospital Admissions from Youth Sports Related Concussions or Head Injuries*

TABLE 3-6 TBI SPORTS-RELATED AND NON-SPORTS-RELATED HOSPITAL DATA
THROUGHOUT NORTHEAST FLORIDA

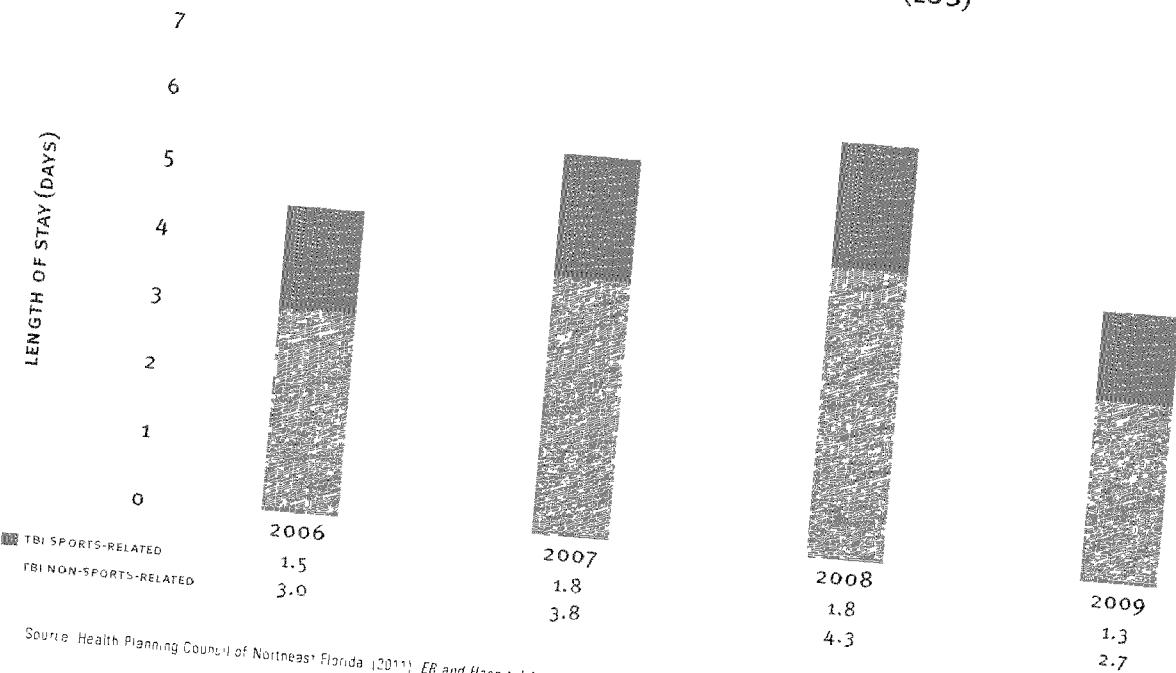
HOSPITAL NAME	TBI SPORTS-RELATED	TBI NON-SPORTS-RELATED	% OF SPORTS-RELATED TBI
FLORIDA HOSPITAL, ORMOND HOSPITAL	37	121	30.6%
BAPTIST MEDICAL CENTER NASSAU	25	136	18.4%
FLORIDA HOSPITAL, FLAGLER	39	169	23.1%
FLORIDA HOSPITAL - DELAND	42	243	17.3%
FLAGLER HOSPITAL	28	299	9.3%
FLORIDA HOSPITAL FISH MEMORIAL	47	322	14.6%
HALIFAX HEALTH MEDICAL CENTER	86	367	23.4%
ORANGE PARK MEDICAL CENTER	60	377	15.9%
SHANDS JACKSONVILLE MEDICAL CENTER	87	958	9.1%
OTHER (HOSPITALS, INCLUDING MAYO CLINIC, WITH COUNTS <25)	124	1,001	12.4%
TOTAL	861	5,067	17.0%

Source: Health Planning Council of Northeast Florida (2011) *ER and Hospital Admissions from Youth Sports Related Concussions or Head Injuries*

HOSPITAL NAME	TBI SPORTS-RELATED	TBI NON-SPORTS-RELATED	% OF SPORTS-RELATED TBI
BAPTIST MEDICAL CENTER JACKSONVILLE	5	16	
SHANDS HOSPITAL JACKSONVILLE	4	177	23.8%

Source: Health Planning Council of Northeast Florida (2011) *ER and Hospital Admissions from Youth Sports Related Concussions or Head Injuries*

CHART 3-38 HOSPITAL ADMISSIONS FOR PATIENTS WITH TBI, SPORTS-RELATED AND NON-SPORTS-RELATED, MEAN LENGTH OF STAY (LOS)



Source: Health Planning Council of Northeast Florida (2011) *ER and Hospital Admissions from Youth Sports Related Concussions or Head Injuries*

CHART 3-39 JUVENILE ARRESTS IN FLORIDA

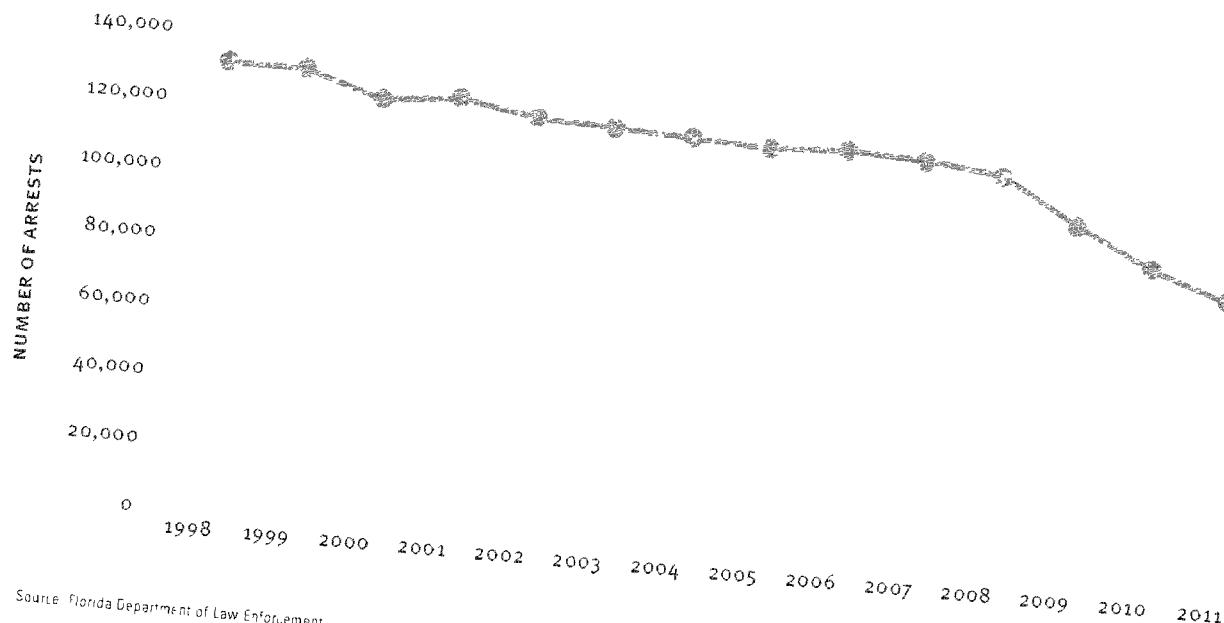


TABLE 3-8 JUVENILE CRIME DATA

	DUVAL COUNTY	STATE OF FLORIDA	UNITED STATES
CARRIED A WEAPON ON SCHOOL PROPERTY AT LEAST 1 DAY	6.5	N/A	5.4
DID NOT GO TO SCHOOL BECAUSE THEY FELT UNSAFE AT SCHOOL OR ON THEIR WAY TO/FROM SCHOOL AT LEAST 1 DAY	11.0	6.5	5.9
THREATENED OR INJURED WITH A WEAPON ON SCHOOL PROPERTY ONE OR MORE TIMES	10.7	7.2	7.4
IN A PHYSICAL FIGHT ON SCHOOL PROPERTY ONE OR MORE TIMES	13.7	10.2	12.0
IN A PHYSICAL FIGHT ONE OR MORE TIMES	32.3	28.0	32.8
CARRIED A GUN AT LEAST 1 DAY	7.1	N/A	5.1
CARRIED A WEAPON AT LEAST 1 DAY	18.8	15.6	16.6

Source: Centers for Disease Control and Prevention – High School Youth Risk Behavior Survey

VITAL STATISTICS

Leading Causes of Death

Cancer is consistently the leading cause of death, responsible for nearly a quarter of deaths in each county of the assessment region. Heart disease, chronic lower respiratory disease and stroke also topped the list in every county. Suicide appeared on the list for St. Johns County, accountable for approximately three percent of deaths. Pneumonia is responsible for the same percentage of deaths in Nassau County. The following tables break down the leading causes of death for each county of the assessment region.

LEADING CAUSES OF DEATH - CLAY COUNTY (2010)

CAUSE OF DEATH	NUMBER OF DEATHS	PERCENT OF TOTAL DEATHS	2010 AGE-ADJUSTED DEATH RATE	3-YEAR AGE-ADJUSTED DEATH RATE
CANCER	357	25.6%	184.7	190.7
HEART DISEASE	272	19.5%	146.0	149.5
CHRONIC LOWER RESPIRATORY DISEASE	98	7.0%	54	56.5
UNINTENTIONAL INJURIES	66	4.7%	36.3	40.6
STROKE	62	4.5%	33.9	33.9
DIABETES	57	4.1%	30.5	25.3

Source: Florida Department of Health, Vital Statistics Bureau

LEADING CAUSES OF DEATH - DUVAL COUNTY (2010)

CAUSE OF DEATH	NUMBER OF DEATHS	PERCENT OF TOTAL DEATHS	2010 AGE-ADJUSTED DEATH RATE	3-YEAR AGE-ADJUSTED DEATH RATE
CANCER	1,611	23.2%	180.2	183.8
HEART DISEASE	1,532	22.1%	170.3	176.1
CHRONIC LOWER RESPIRATORY DISEASE	436	6.3%	50.4	49.8
UNINTENTIONAL INJURIES	367	5.3%	39.9	40.3
STROKE	288	4.1%	32.1	35.7
DIABETES	237	3.4%	26.6	28.2

Source: Florida Department of Health, Vital Statistics Bureau

LEADING CAUSES OF DEATH – NASSAU COUNTY (2010)

CAUSE OF DEATH	NUMBER OF DEATHS	PERCENT OF TOTAL DEATHS	2010 AGE-ADJUSTED DEATH RATE	3-YEAR AGE-ADJUSTED DEATH RATE
CANCER	151	23.2%	155.4	165.5
HEART DISEASE	139	21.3%	159.2	168.7
CHRONIC LOWER RESPIRATORY DISEASE	44	6.7%	48.9	52.2
UNINTENTIONAL INJURIES	42	6.4%	54.0	56.3
STROKE	27	4.1%	30.9	31.4
	15	2.3%	18.6	20.4

Source: Florida Department of Health Vital Statistics Bureau

LEADING CAUSES OF DEATH – PUTNAM COUNTY (2010)

CAUSE OF DEATH	NUMBER OF DEATHS	PERCENT OF TOTAL DEATHS	2010 AGE-ADJUSTED DEATH RATE	3-YEAR AGE-ADJUSTED DEATH RATE
CANCER	226	23.0%	212.9	203.2
HEART DISEASE	198	20.1%	184.3	163.5
CHRONIC LOWER RESPIRATORY DISEASE	73	7.4%	64.6	66.7
UNINTENTIONAL INJURIES	62	6.3%	86.9	72.0
STROKE	49	5.0%	43.9	43.6
DIABETES	42	4.3%	37.4	37.0

Source: Florida Department of Health Vital Statistics Bureau

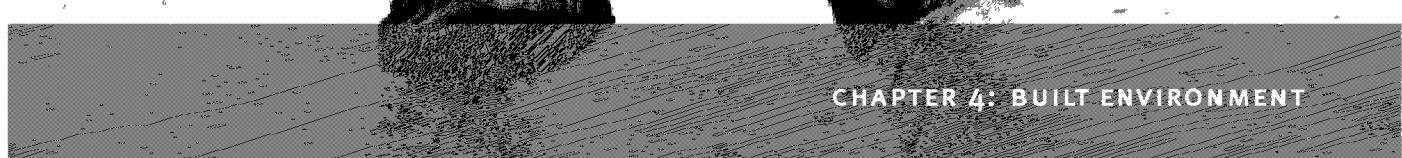
LEADING CAUSES OF DEATH – ST. JOHNS COUNTY (2010)

CAUSE OF DEATH	NUMBER OF DEATHS	PERCENT OF TOTAL DEATHS	2010 AGE-ADJUSTED DEATH RATE	3-YEAR AGE-ADJUSTED DEATH RATE
CANCER	378	25.7%	153.0	159.7
HEART DISEASE	290	19.7%	113.3	109.2
CHRONIC LOWER RESPIRATORY DISEASE	85	5.8%	34.3	35.2
STROKE	65	4.4%	26.1	26.1
UNINTENTIONAL INJURIES	62	4.2%	29.7	32.5
	42	2.9%	19.8	15.9

Source: Florida Department of Health Vital Statistics Bureau



CHAPTER 4: BUILT ENVIRONMENT



NATURAL AMENITIES SCALE

The natural amenities scale is a measure of the physical characteristics of a county area that enhance the location as a place to live. The scale was constructed by combining six measures of climate, topography and water area that reflect the environmental qualities most people prefer. These measures are warm winter, winter sun, temperate summer, low summer humidity, topographic variation and water area.⁶ Natural amenity rankings are given values "1" through "7," with "7" representing the highest score.

St. Johns and Putnam Counties were scored at a "5," while the other counties in the assessment region all received a score of "4." On a scale of "7," a score of "3" would indicate an average score, as it falls exactly in the middle. Thus, while the county scores are not the highest possible, they are still above average. The standard deviations listed in Table 4-1 put these scores in context and provide a better idea of how high each score is.

AMERICAN LUNG ASSOCIATION: STATE REPORT CARD

The American Lung Association (ALA) assigns grades "A" through "F" based on average annual number of days that ozone levels exceeded U.S. standards during the three-year measurement period.⁷ The weighted average was derived by adding the three years of individual level data (2008 through 2010), multiplying the sums of each level by the assigned standard weights (i.e., "1" = orange, "1.5" = red, "2.0" = purple and "2.5" = maroon) and calculating the average. Grades are assigned based on the weighted averages as follows: "A" = 0.0, "B" = 0.3 to 0.9, "C" = 1.0 to 2.0, "D" = 2.1 to 3.2, "F" = 3.3+.⁸

Duval County is the only county in the assessment region for which the ALA reports data. As shown in Table 4-2, Duval County was given a grade of "B" for both ozone levels and particle pollution for the years of 2008 through 2010.

Blood Lead Levels

According to Florida's definition of childhood lead poisoning, children ages 72 months or younger with confirmed lead levels greater than or equal to 10 micrograms per deciliter are considered lead poisoned. This is the same definition as the Centers for Disease Control and Prevention.⁹

The data available on the subject are provided in Table 4-3. Note that a very small sample of children from each county was tested. Even so, St. Johns County did not have any incidences of elevated blood lead levels. On the other hand,

Water Fluoridation

Fluoridating the public water supply is the most cost-effective means of preventing dental decay with positive effects ranging throughout all ages. The constant contact of low concentrations of fluoride in the oral cavity that occurs when people drink fluoridated water has been shown to significantly reduce dental

¹⁰

⁶ United States Department of Agriculture, Economic Research Service <http://www.ers.usda.gov/data-products/natural-amenities-scale.aspx>

⁷ NE FL Counts <http://www.nefloridacounts.org/modules.php?op=modload&name=NS-Indicator&file=indicator&id=15887>

⁸ American Lung Association <http://www.stateoftheair.org/2012/states/understanding-the-grades-and-tables.html>

⁹ Florida Department of Health http://www.doh.state.fl.us/environment/learning/lead_prevention.htm

¹⁰ Florida Department of Health *Community Water Fluoridation* <http://www.doh.state.fl.us/family/dental/fluoridation/index.htm>

Duval County has the largest percentage of both populations that receive fluoridated water (more than 90 percent) Clay County has the lowest levels (eight percent of water system population fluoridated) (See Chart 4-1.)

Key Findings

- All five counties in the assessment region scored higher than average in natural amenities, but Putnam and St. Johns Counties scored the highest at "5"
- Duval County was given grades of "B" in both aspects of air quality
- St. Johns County was the only county in the assessment region with no incidences of elevated blood lead levels
- All counties provide fluoridated water; however only eight percent of the water system in Clay County is fluoridated, while more than 90 percent of the system in Duval County receives fluoridated water

TABLE 4-1 NATURAL AMENITIES SCALE

	SCALE SCORE	STANDARD DEVIATIONS
ST. JOHNS	5	2.98
PUTNAM	5	2.35
DUVAL	4	2.31
NASSAU	4	2.04
CLAY	4	2.01

Source: USDA Economic Research Service

TABLE 4-2 AIR QUALITY - DUVAL COUNTY

OZONE		PARTICLE POLLUTION	
GRADE	WEIGHTED AVERAGE	GRADE	WEIGHTED AVERAGE
B	0.7	B	0.3

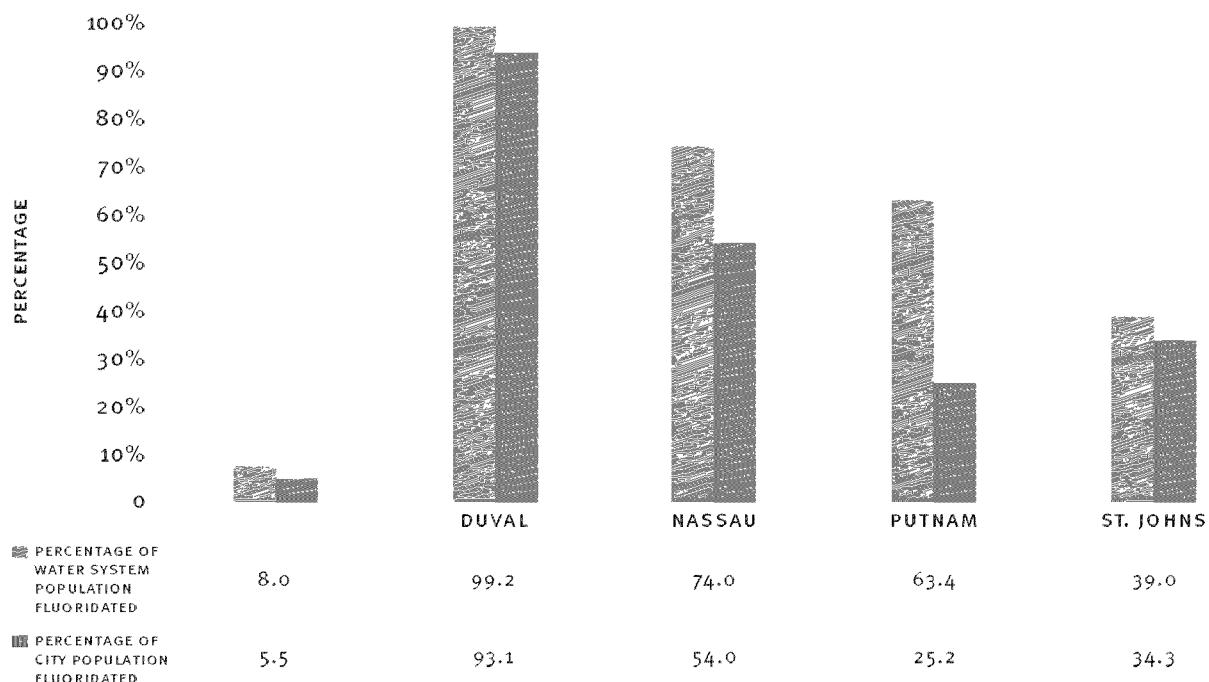
Source: American Lung Association, State Report Card

TABLE 4-3 BLOOD LEAD LEVELS

COUNTY	PERCENT OF CHILDREN TESTED	PERCENT OF CHILDREN WITH ELEVATED BLOOD LEAD LEVELS
CLAY	5.60%	0.12%
DUVAL	6.90%	0.21%
PUTNAM	9.10%	0.55%
ST. JOHNS	3.30%	0.00%

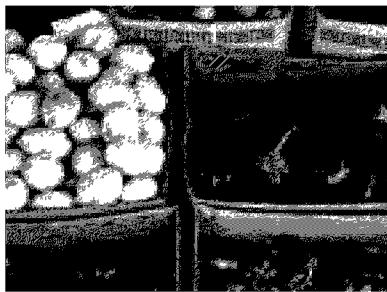
Source: CDC Blood Lead Surveillance Report

CHART 4-1 WATER FLUORIDATION



Source: Florida Department of Health <http://www.doh.state.fl.us/family/dental/fluoridation/optimally2007.pdf>





SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

The number of food stamp recipients climbed by about 10 million from 2007 to 2009¹¹ Thus, the observed increase in SNAP-authorized stores is likely due to the increased demand for such establishments All five counties in the assessment region have seen an increase in the rate of SNAP-authorized stores since 2008 In 2010, Putnam County had the highest rate at 1 48 stores per 1,000 individuals St Johns County had the lowest rate at 0 53 stores per 1,000 people (see Chart 5-1)

WOMEN, INFANTS AND CHILDREN (WIC)

While there are more SNAP-authorized stores, the rates of WIC-authorized stores have stayed the same Chart 5-2 illustrates that the largest change in either direction was by 0 02 When the rates for SNAP- and WIC-authorized stores are viewed side-by-side, the low levels of WIC-authorized stores are put into perspective. In using the most optimistic numbers (from Putnam County), the rate equates to approximately one store for every 6,600 individuals See Chart 5-3 for further comparison

ACCESS TO FOOD SOURCES

The distribution of various food sources varies by county In Nassau and St Johns Counties, there are more full-service restaurants than fast food restaurants However, in Clay and Duval Counties the opposite is true All of the assessment region counties share a relatively low rate of farmers' markets (no higher than 0 2 markets per 1,000 people in any county) Additionally, convenience stores make up a large majority of the stores available to residents of all five counties In Putnam County specifically, there are three times as many convenience stores than all other types of stores (supercenters, grocery stores, specialized food stores) combined Charts 5-4 and 5-5 provide more information about the types of food sources available in each county When considering access to food that is greater than one mile away, those individuals identified as low-income have less difficulty than those without a car, this is true for all five counties

This becomes more obvious when the distance radius is increased to 10 miles See Charts 5-7 and 5-8 to compare Note the scales for the two charts are very different Maps 5-1 through 5-4 help to visualize the food deserts in Clay, Duval, Putnam and St. Johns Counties.

The percentage of students eligible for free or reduced school lunch is highest in Putnam County (nearly 75 percent) See Chart 5-6 for percentages in the rest of the assessment region

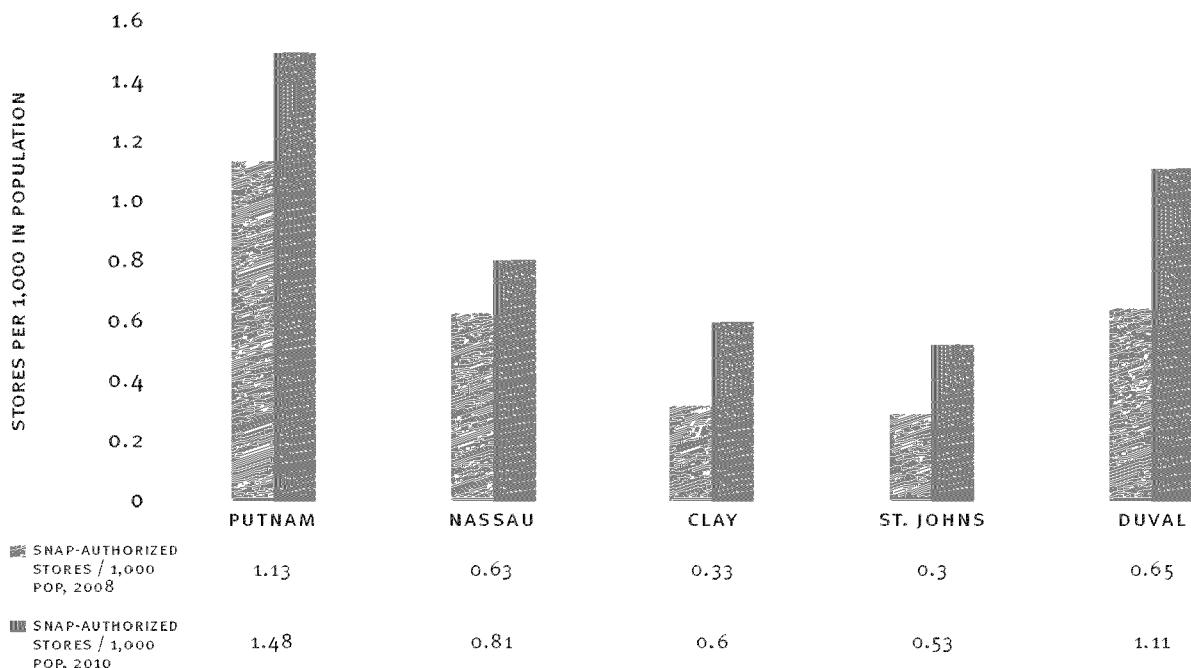
Focus group participants expressed their concerns about individual eating habits and choices In the survey, 47 percent of respondents indicated that they had not consumed the recommended amount of fruit and 58 percent did not eat enough vegetables Focus group participants have noticed many people skipping the produce aisle and heading for foods that are cheaper and easier to prepare This type of decision-making extends beyond what they buy in the grocery store, when convenience stores are so prevalent, the decision becomes about where to go to buy food, not just what food to buy.

11 The New York Times *Food Stamp Usage Across the Country* <http://www.nytimes.com/interactive/2009/11/28/us/20091128-foodstamps.html>

Key Findings

- SNAP-authorized stores have increased along with increased enrollment, but WIC-authorized store rates have stayed the same
- Residents in all five counties have limited availability of local food sources (i.e., farmers' markets) Additionally, there are high rates of convenience stores which for many serve as food sources
- In Putnam County specifically, there are three times as many convenience stores than all other types of stores (supercenters, grocery stores, specialized food stores) combined
- The data imply that a lack of personal transportation is a greater barrier than being identified as "low-income"

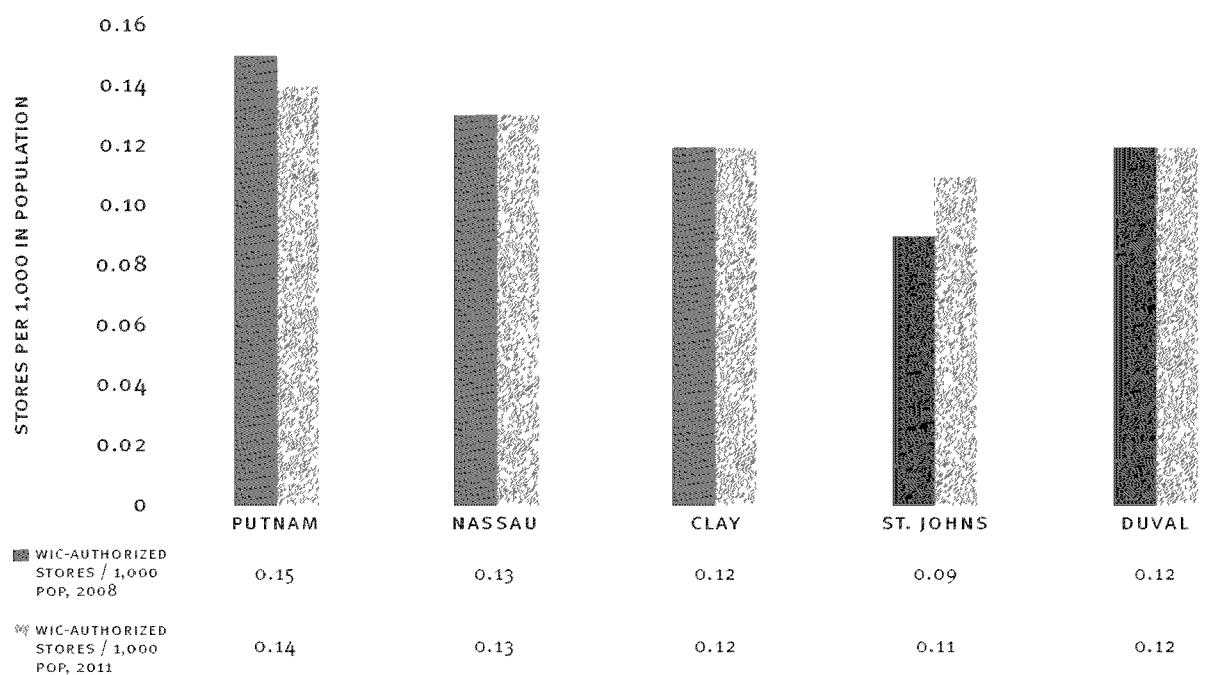
CHART 5-1 SNAP-AUTHORIZED STORES



Source: United States Department of Agriculture

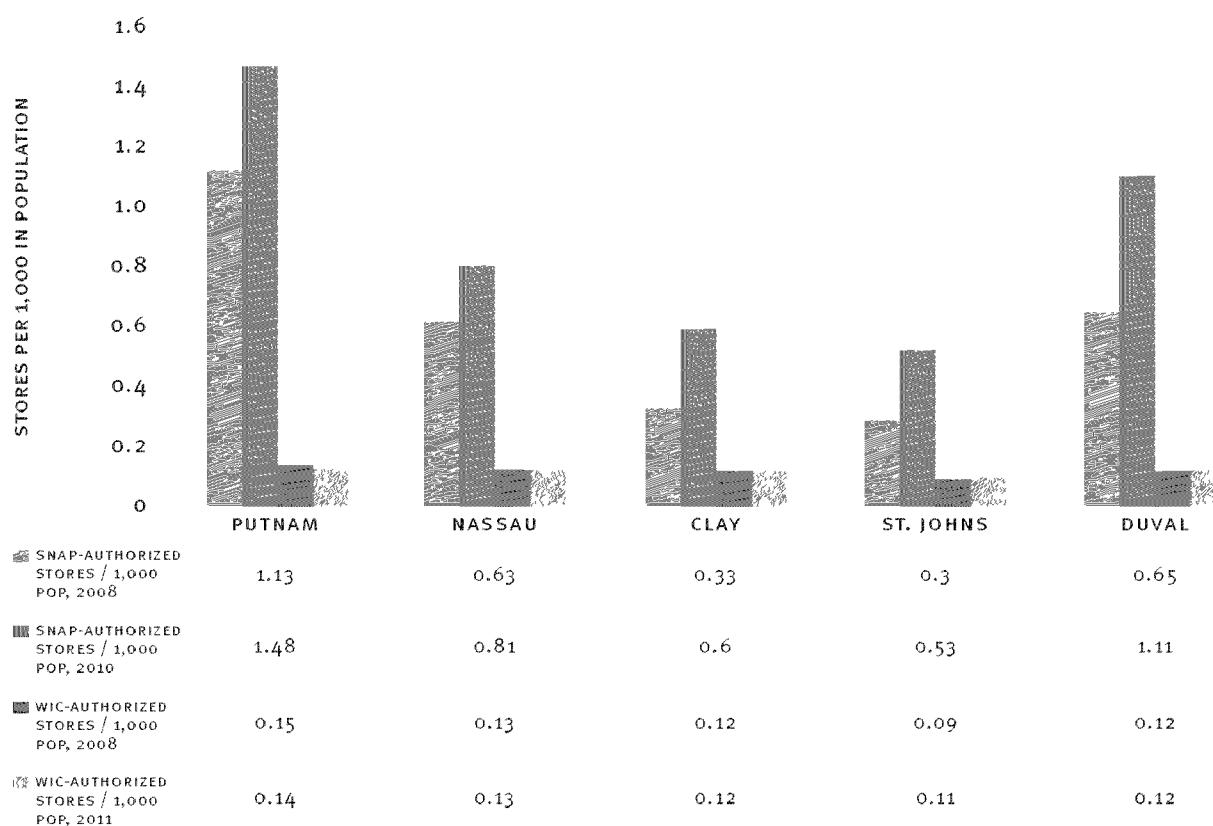
11 The New York Times Food Stamp Usage Across the Country <http://www.nytimes.com/interactive/2009/11/28/us/20091128-foodstamps.html>

CHART 5-2 WIC-AUTHORIZED STORES



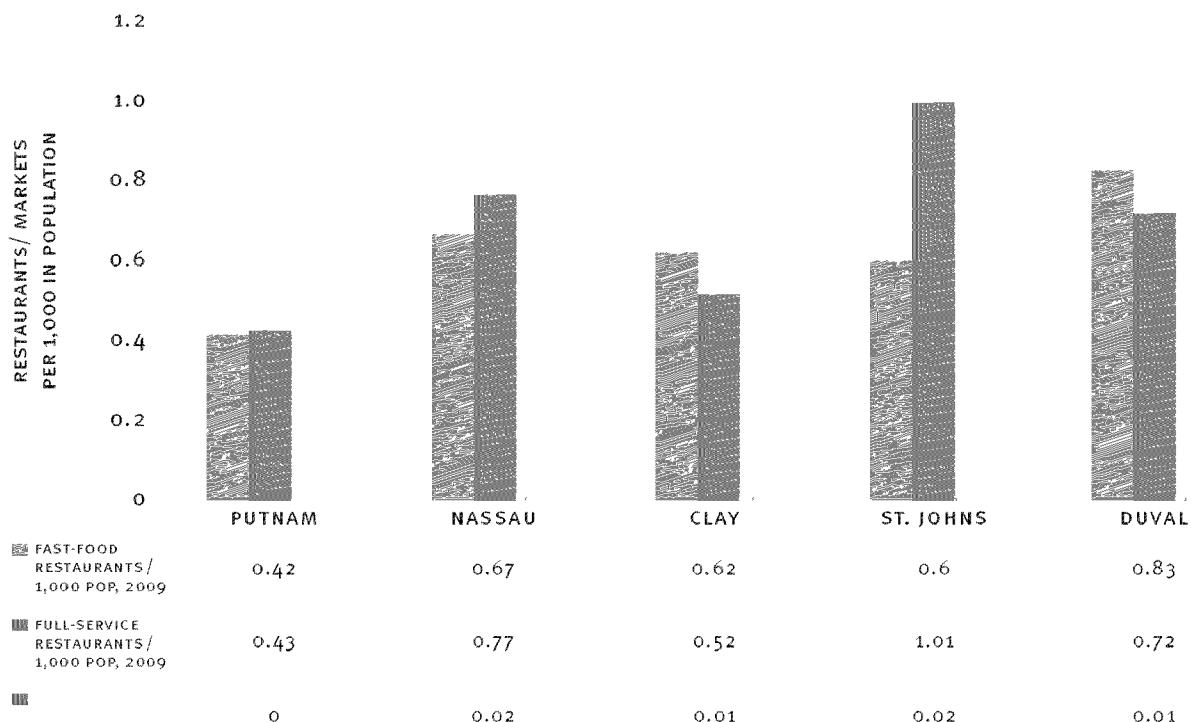
Source: United States Department of Agriculture

CHART 5-3 SNAP- AND WIC-AUTHORIZED STORES



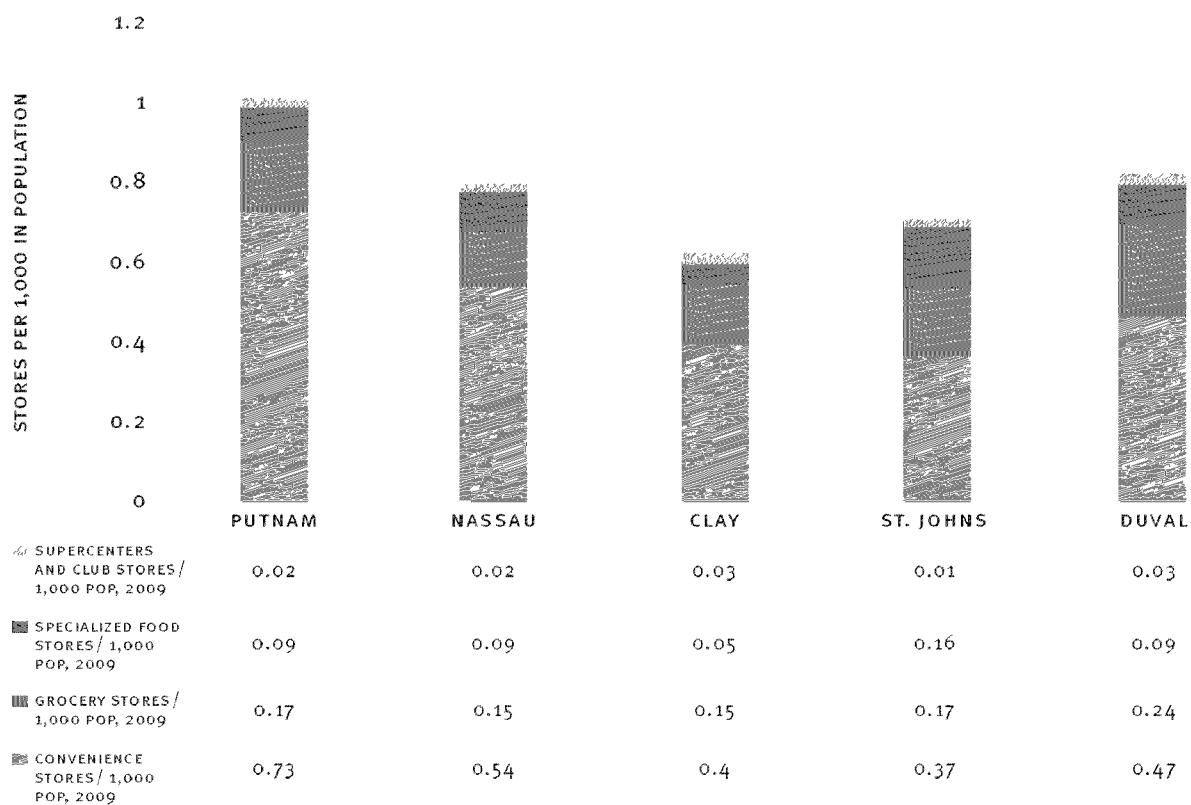
Source: United States Department of Agriculture

CHART 5-4 RESTAURANT AVAILABILITY



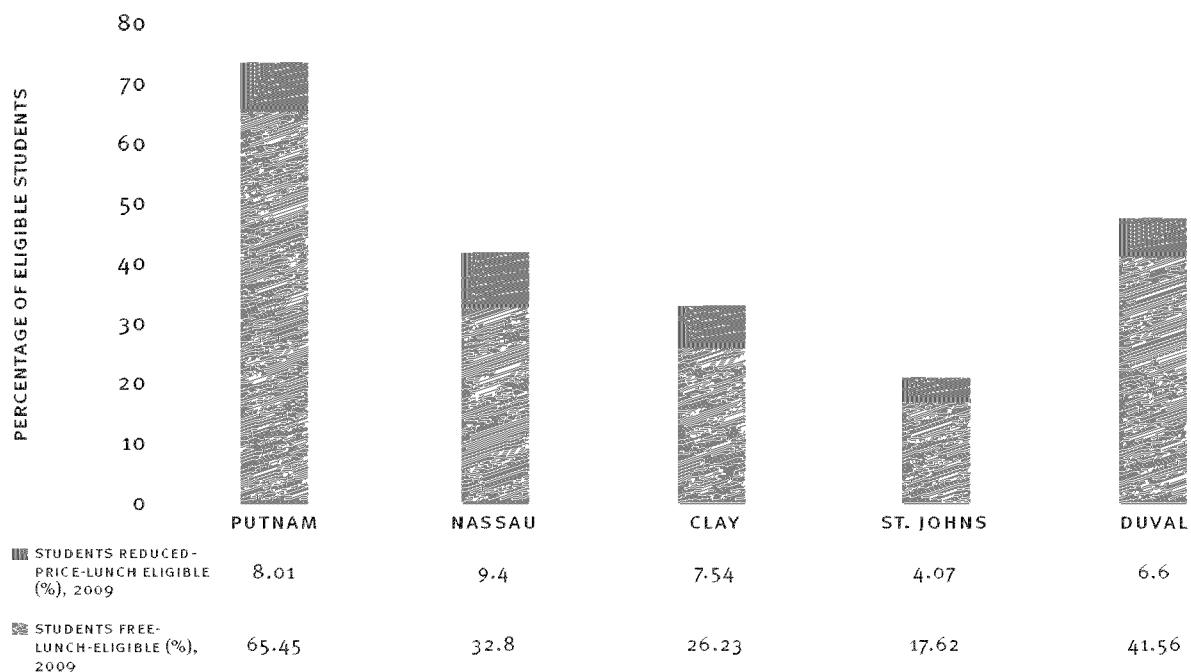
Source: United States Department of Agriculture

CHART 5-5 STORE AVAILABILITY



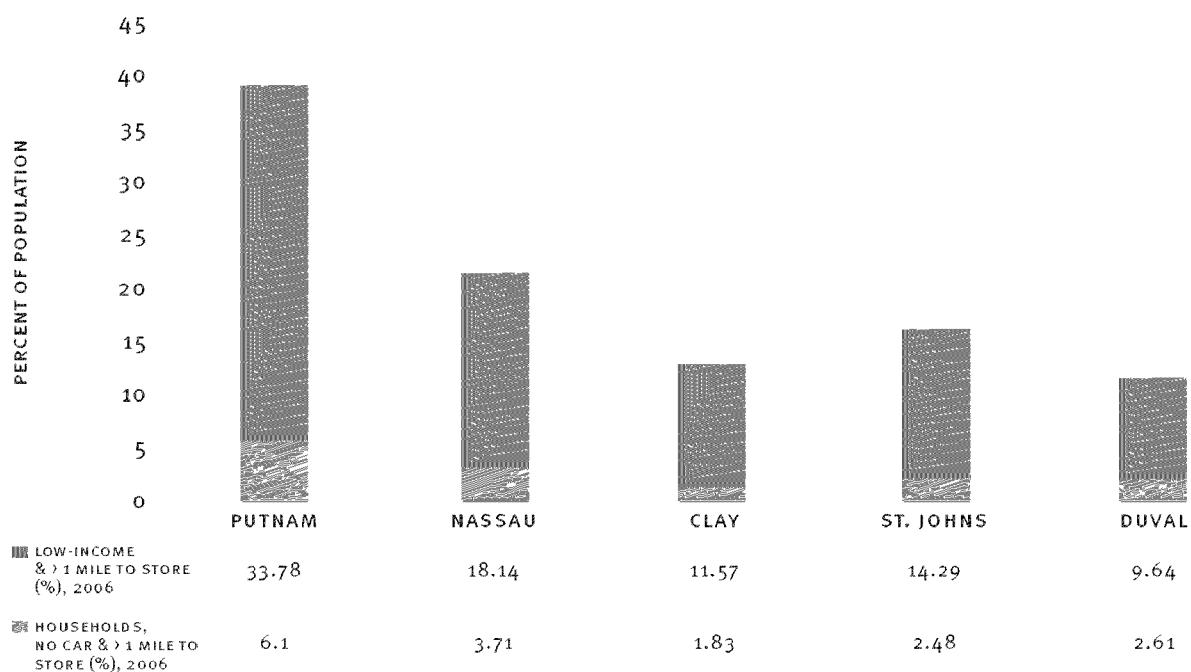
Source: United States Department of Agriculture

CHART 5-6 ELIGIBILITY FOR FREE AND REDUCED-PRICE LUNCHES



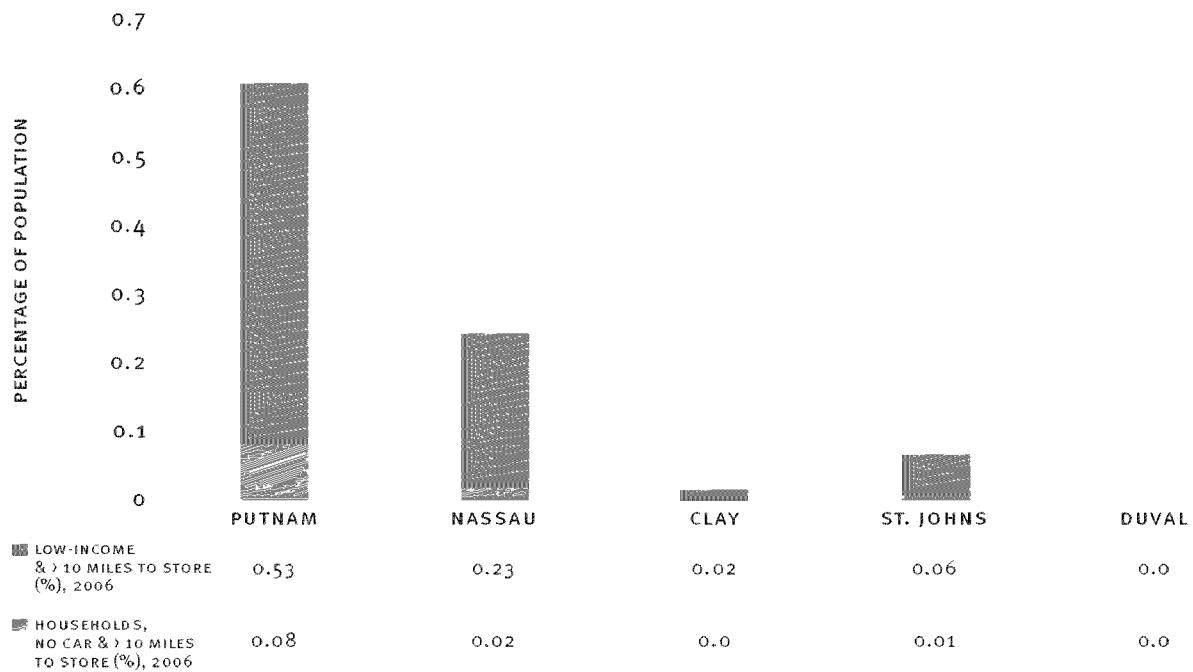
Source: United States Department of Agriculture

CHART 5-7 ACCESS TO FOOD, GREATER THAN ONE MILE



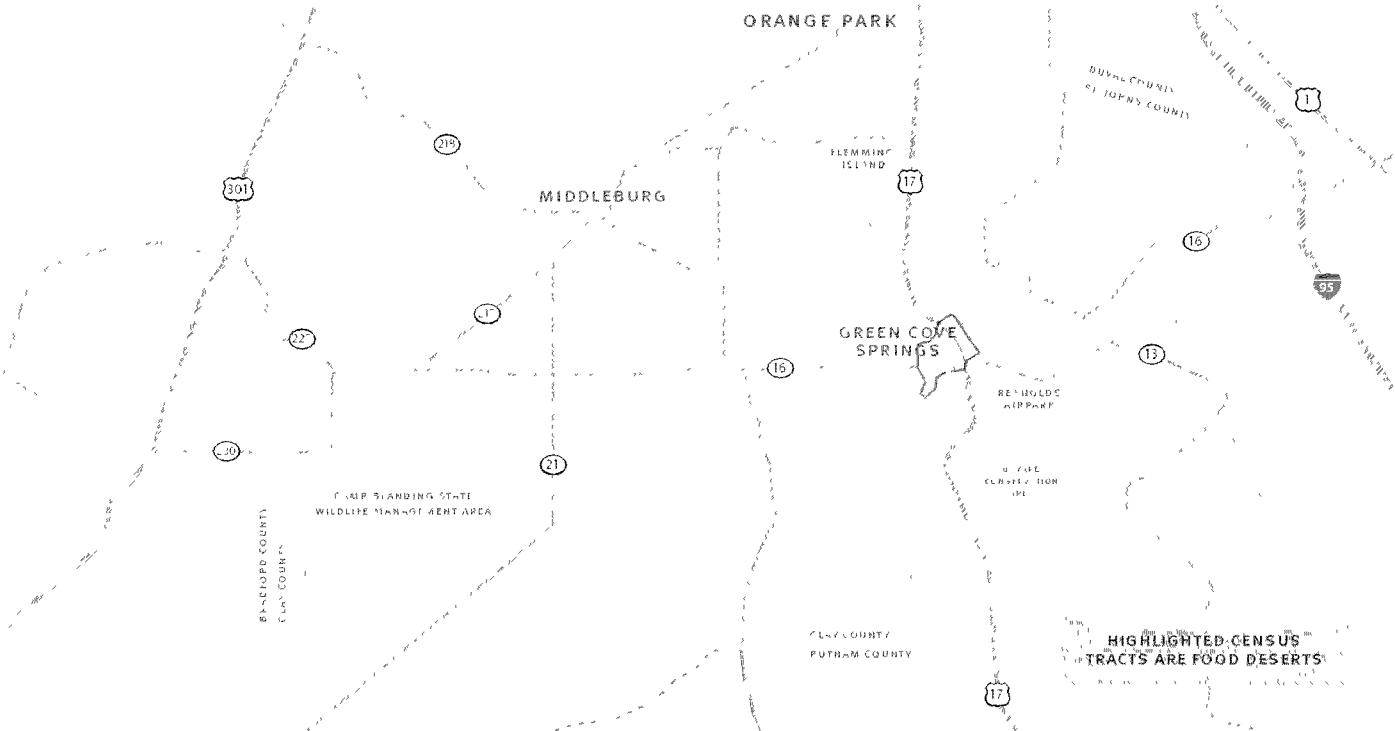
Source: United States Department of Agriculture

CHART 5-8 ACCESS TO FOOD, GREATER THAN 10 MILES



Source: United States Department of Agriculture

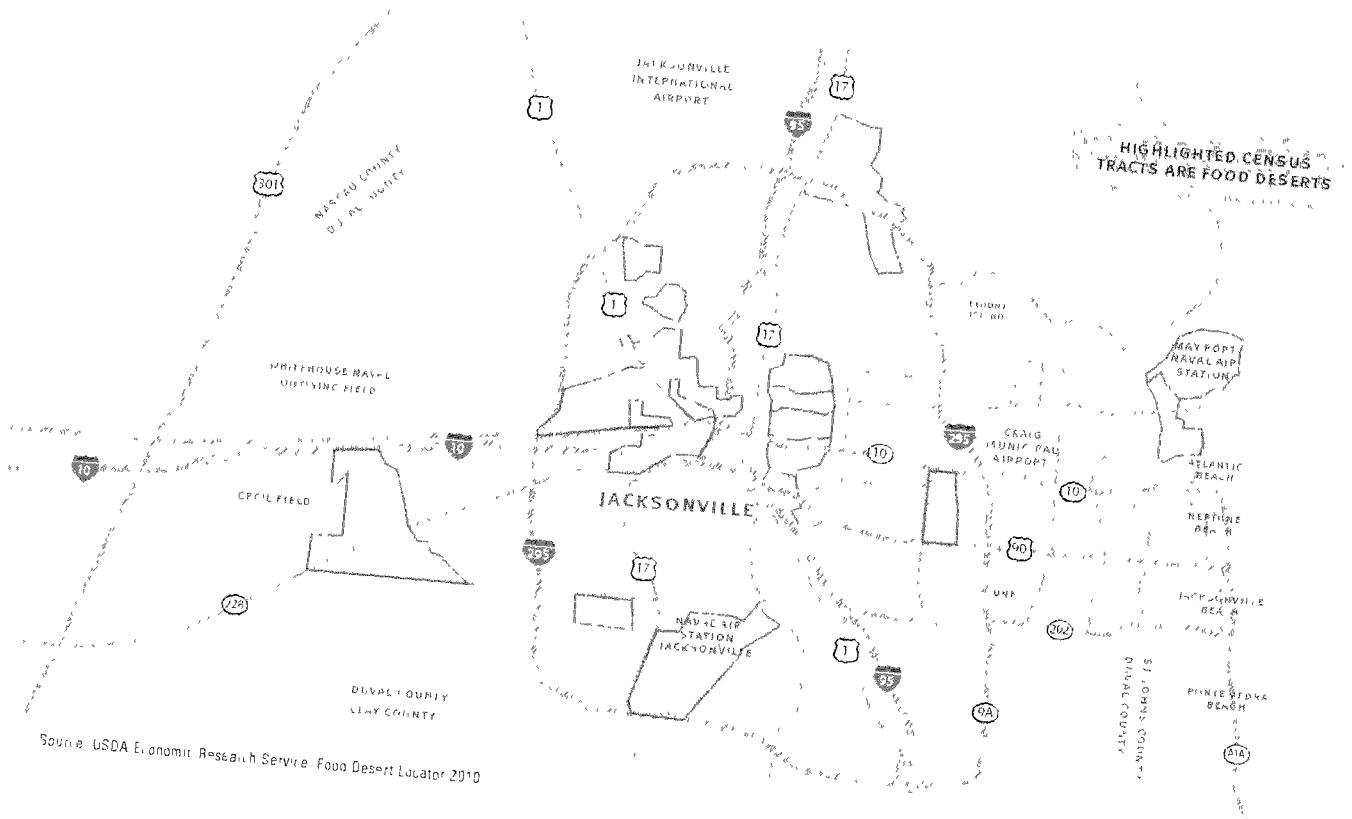
MAP 5-1 CLAY COUNTY



Source: USDA Economic Research Service

October 2010

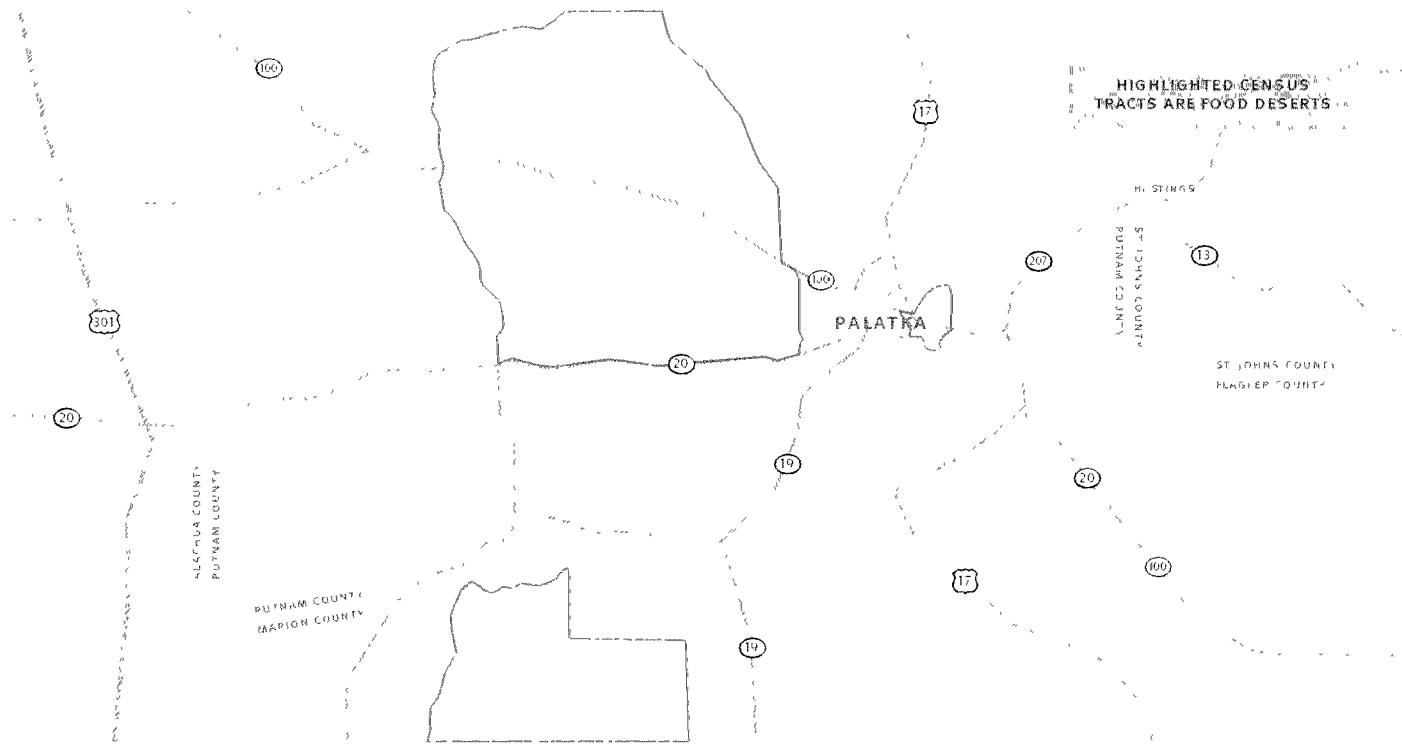
MAP 5-2 DUVAL COUNTY



MAP 5-3 NASSAU COUNTY

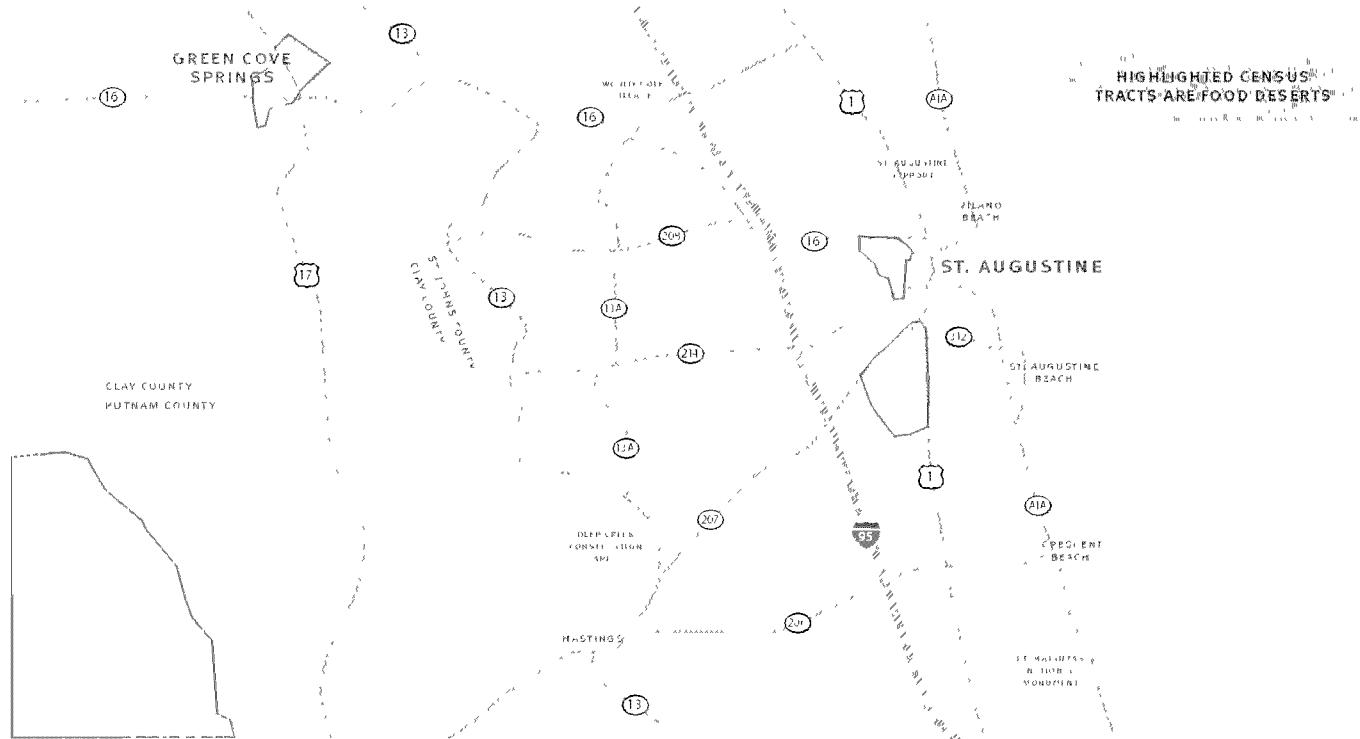
No food deserts were identified in Nassau County, Florida according to USDA Economic Research Services, Food Desert locator 2010

MAP 5-4 PUTNAM COUNTY



Source: USDA Economic Research Service Food Desert Locator 2010

MAP 5-5 ST. JOHNS COUNTY



Source: USDA Economic Research Service Food Desert Locator 2010



CHAPTER 6: HEALTH CARE ACCESS

Access to health care services is an important determinant of health status and continues to be a central focus for health policy in Florida. The following summary provides a review of health coverage available to Clay, Duval, Nassau, Putnam and St. Johns County residents, health care providers practicing in the counties, health care facilities and services, and other community resources. An assessment of existing health care systems will help to identify the current status of care availability and significant gaps or challenges.

According to the Community Health Survey used for this assessment, access to health care is important to a majority of respondents (96 percent). Statistical tests showed that significant differences exist across gender and race/ethnicity. Female respondents (97 percent) found access to health care to be more important than males (94 percent). Females (84 percent) also responded "very important" more than males (67 percent). Other/Multi-Racial respondents placed the lowest level of importance on access to health care (73 percent), while Hispanic respondents unanimously answered "very important" or "somewhat important" (100 percent). A closer look at strictly "very important" responses shows that African-American respondents answered this way the most (93 percent). It is important to note that none of the respondents answered "not at all important."

QUALITY OF CARE

Sixty-five percent of the respondents of the Community Health Survey rated the quality of health care services in their county as "excellent or good." Forty-seven of those percent were "good" responses. Five percent of respondents rated the health care services as "poor."

St. Johns County respondents were most satisfied with the health care services in their county (79 percent) and submitted the highest level of "excellent" ratings (30 percent). Duval County residents were least satisfied (61 percent) and gave the highest percentage of "poor" ratings. Respondents from Clay County gave the fewest "excellent" ratings (11 percent).

Males (71 percent) tended to rate the health care services in their counties higher than females (61 percent). They also gave more "excellent" ratings (22 percent) than women (16 percent).

Asian respondents were most satisfied with the health care services (78 percent). Interestingly, African-American respondents were the least satisfied overall (53 percent) but gave the highest level of "excellent" ratings. This signals a divide in beliefs; a high number of people rated their services as "excellent," however an almost equally large number of people were displeased with the quality.

Ratings of health care services tend to improve as the age of the respondent increases, with a slight drop-off for those in the ages 75 and older group. Those respondents ages 18 to 24 gave their services the lowest rating (54 percent), but it was the ages 25 to 34 group that responded with the least percentage of "excellent" responses. Respondents ages 65 to 74 gave the highest ratings (87 percent), but individuals ages 75 and older responded with the highest "excellent" responses (46 percent).

Ratings of health care quality increased as income increased. Those in the Under \$15,000 bracket gave the lowest overall rating (46 percent), while those at the highest end of the income scale gave an 80 percent rating and the highest percentage of "excellent" ratings (27 percent). Those in the \$50,000 to \$74,999 income range gave the lowest amount of "excellent" ratings (12 percent).

Key Findings:

- Sixty-five percent of the survey respondents rated the quality of health care services in their county as "excellent or good." Forty-seven percent of those were "good" responses.
- St. Johns County respondents were most satisfied with the health care services in their county (79 percent) and submitted the highest level of "excellent" ratings. Duval County residents were the least satisfied and gave the highest percentage of "poor" ratings. Respondents from Clay County gave the fewest "excellent" ratings.
- African-American respondents were the least satisfied overall (53 percent) but gave the highest level of "excellent" ratings. This signals a divide in beliefs; a high number of people rated their services as "excellent," however an almost equally large number of people were displeased with the quality.

HEALTH CARE PROVIDERS AND FACILITIES

The Community Health Survey revealed several interesting findings regarding accessibility of health care, delays in treatment, routine care, and tests and screenings, insurance coverage and other barriers to care. Findings from the 22 consumer-based focus groups conducted across the selected counties supported much of the findings from the community needs assessment. The Department of Health and Human Services (HHS) has designated each of the low-income populations in Clay, Duval, Nassau, Putnam and St. Johns Counties as a Medically Underserved Population (MUP). In addition, Clay, Duval, Nassau, Putnam and St. Johns Counties are all designated as Health Professional Shortage Areas (HPSA) for the low-income population in the areas of Primary Care, Dental Care and Behavioral Health. I.M. Sulzbacher Center for the Homeless, the Duval County Health Department, Rural Healthcare, Inc., Sunrise Primary Care and Northeast Florida Health Services are to address health care access needs of the low-income population in Northeast Florida.

Accessing Health Care or Physicians

Eighty-one percent of survey respondents reported that they "did not have a time during the past 12 months when they or anyone in their household experienced difficulties getting or delayed receiving health care for any reason."

Ten percent of respondents reported that they "had experienced a time during the past 12 months when they needed medical care, but had difficulty finding a doctor." Five percent of respondents with children reported that they "had a time in the past 12 months when they needed medical care for a child in their care, but they could not receive it."

When _____ were asked where they would most likely go if their children or dependents were sick, the majority of respondents (83 percent) said that they would be "most likely to go to the doctor's or pediatrician's office/clinic if their children or dependents were sick." The next most common answer was the "hospital Emergency Room" (15 percent) followed by an "urgent care or walk-in clinic" (10 percent). No respondents said that they would "rely on a school nurse/clinic."

Ninety-three percent of respondents who get a prescription for medications to treat an illness said that they "get their prescription(s) filled at a pharmacy." Five percent reported that they "go without medicine" and an additional five percent reported that they "buy over-the-counter medicine instead."

When disabled respondents were asked to identify the biggest issue they face regarding health care access, the four most common issues were, "don't have/can't get health insurance" (11 percent), "mobility," in general, (10 percent), "walking" (eight percent) and "cost of care/medications/equipment" (eight percent).

Just under half of the respondents (49 percent), reported that their most recent visit to the dentist or dental clinic was within the past six months. Eleven percent of respondents reported that they had not made a visit to the dentist or dental clinic in five or more years.

Delays in Accessing Health Care or Physicians

Of those who had delayed health care services in the last 12 months, 73 percent had delayed a visit to a doctor or physician. The next most delayed service was medical test, exam or screening (42 percent). The third most delayed service was dental care (28 percent). Ten percent of respondents answered "other services."

The types of doctor or physician visits that the respondent or a household member delayed most frequently in the past 12 months were "routine care" (54 percent), "chronic condition" (47 percent), "minor illness/injury" (36 percent) and "dental care" (35 percent). Sixteen percent of respondents answered "other visits."

Forty-eight percent of respondents with children "visited a doctor for a routine checkup or general physical exam within the past six months." The percentage of children who "had not visited a doctor for a routine checkup or general physical exam within the past six months in five or more years" was zero percent.

Delays in Tests and Screenings

Twenty-seven percent of respondents specified “other tests”

When parents were asked how long it had been since their child visited a dentist or dental clinic, the largest group of respondents answered “within the past six months” (43 percent). Sixteen percent of the respondents said that their “child has never visited a dentist or dental clinic”

Reasons for Delays in Accessing Health Care

The three most frequently noted reasons for delaying health care treatment are “inability to pay” (38 percent), “no insurance” (35 percent) and “concerned about spending in current economy” (33 percent) Twenty-five percent of respondents answered “other reasons”

Respondents reported the main obstacle to getting medical care for children as “cost/no insurance/could not afford it” (67 percent) The next most common obstacle reported was “too long of a wait for an appointment” (10 percent)

According to the survey, 19 percent of respondents, or someone in their household, “needed a prescription medicine, but did not get it because they could not afford it”

Key Findings:

- Eighty-one percent of survey respondents did not have a time during the past 12 months when they or anyone in their household experienced difficulties getting or delayed receiving health care for any reason; 10 percent of respondents experienced a time during the past 12 months when they needed medical care but had difficulty finding a doctor Five percent of respondents with children had a time in the past 12 months when they needed medical care for a child in their care but could not get it
- When disabled respondents were asked to identify the biggest issue they face in accessing health care, the four most common answers were, “don’t have/can’t get health insurance” (11 percent), “mobility, in general (10 percent), “walking” (eight percent) and “cost of care/medications/equipment” (eight percent)
- Just under half of the respondents (49 percent) reported that their most recent visit to the dentist or dental clinic was within the past six months For 11 percent of respondents, this visit had not occurred in five or more years
- Of those who had delayed health care services in the last 12 months, 73 percent had delayed a visit to a doctor or physician The next most delayed service was medical test, exam or screening (42 percent) The third most delayed service was dental care (28 percent) Ten percent of respondents answered “other services.”
- The types of doctor or physician visits that respondents, or a member of their household, delayed most frequently in the past 12 months were “routine care” (54 percent), “chronic condition” (47 percent), “minor illness/injury” (36 percent) and “dental care” (35 percent) Sixteen percent of respondents answered “other visits”
- Forty-eight percent of respondents with children “visited a doctor for a routine checkup or general physical exam within the past six months” The percentage of children who “had not visited a doctor for a routine checkup or general physical exam within the past six months in five or more years” was zero percent
- Sixteen percent of the survey respondents reported that their “child has never visited a dentist or dental clinic”
- The three most frequently noted reasons for delaying health care treatment are, “inability to pay” (38 percent), “no insurance” (35 percent) and “concerned about spending in current economy” (33 percent) Twenty-five percent of respondents answered “other reasons”
- The main obstacle to getting medical care for children was reported as “cost/no insurance/could not afford it” (67 percent). The next most common obstacle reported was “too long of a wait for an appointment” (10 percent)
- Nineteen percent of respondents, or someone in their household, “needed a prescription medicine but did not get it because they could not afford it”

CHART 6-1

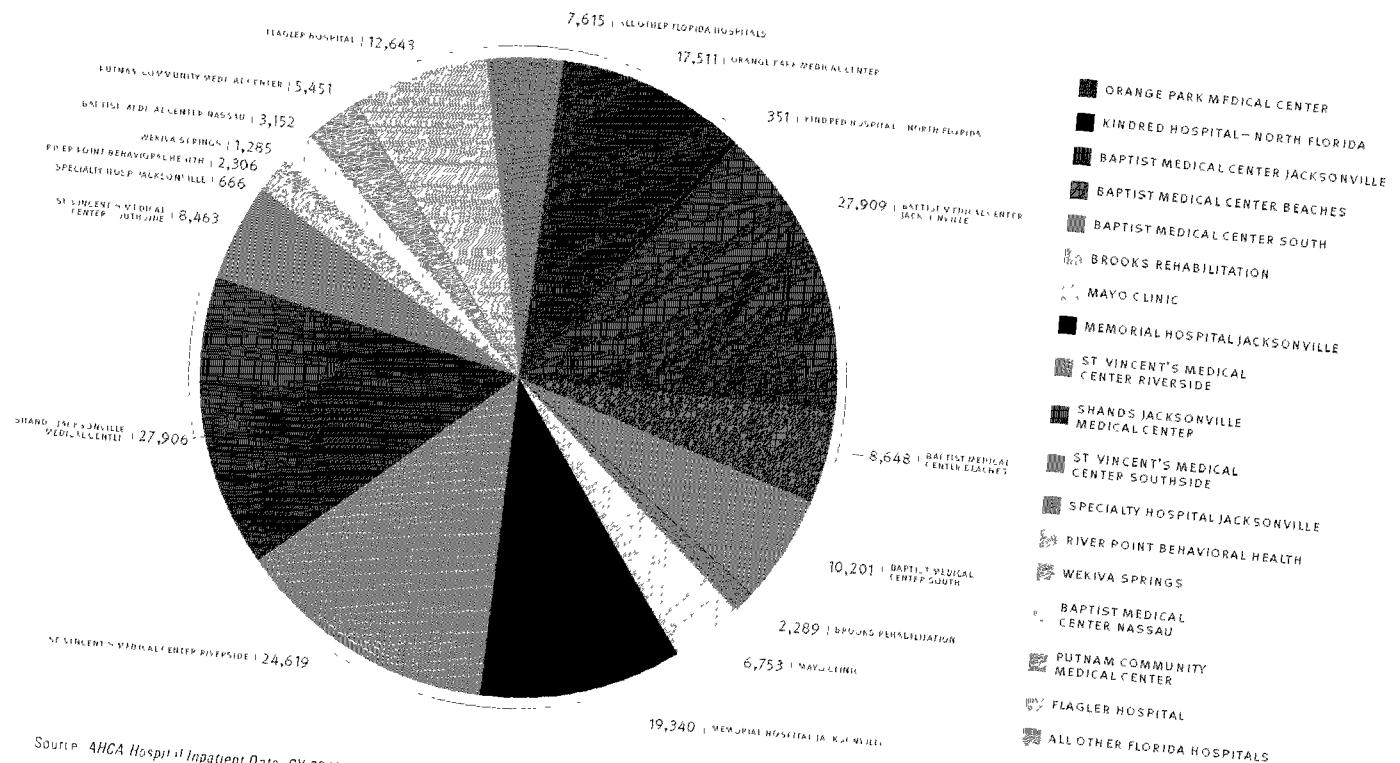


CHART 6-2 TOTAL LICENSED PHYSICIANS

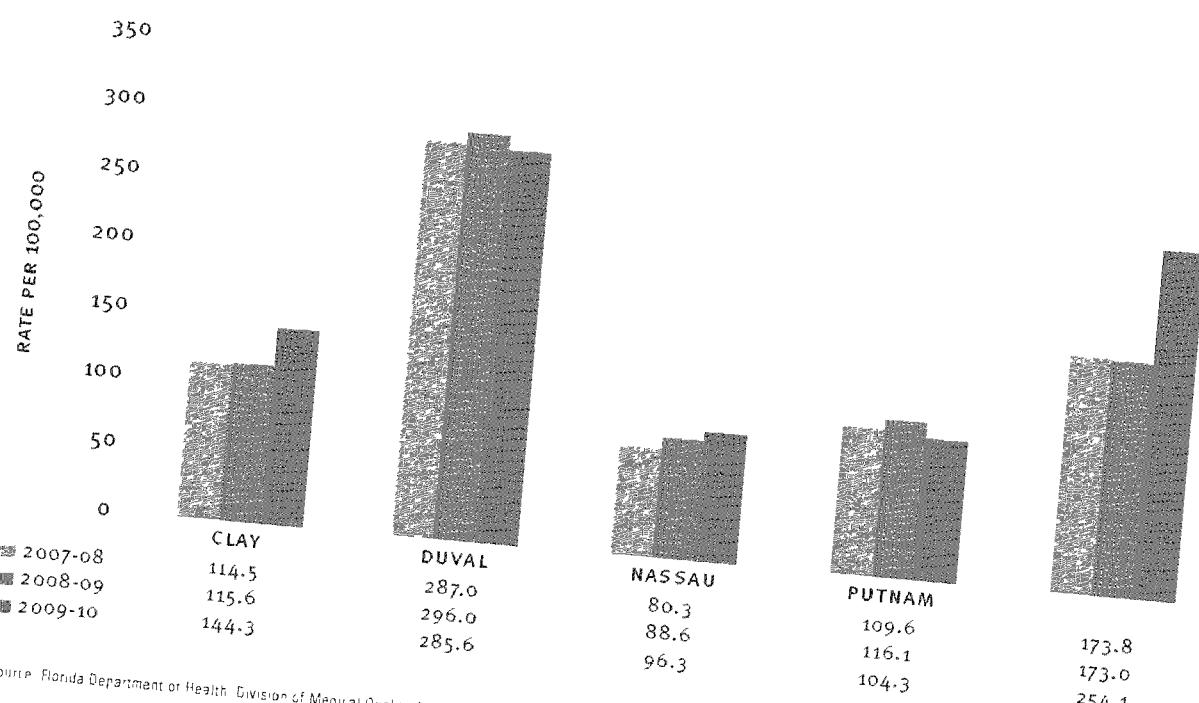


CHART 6-3 TOTAL LICENSED PRIMARY CARE PHYSICIANS

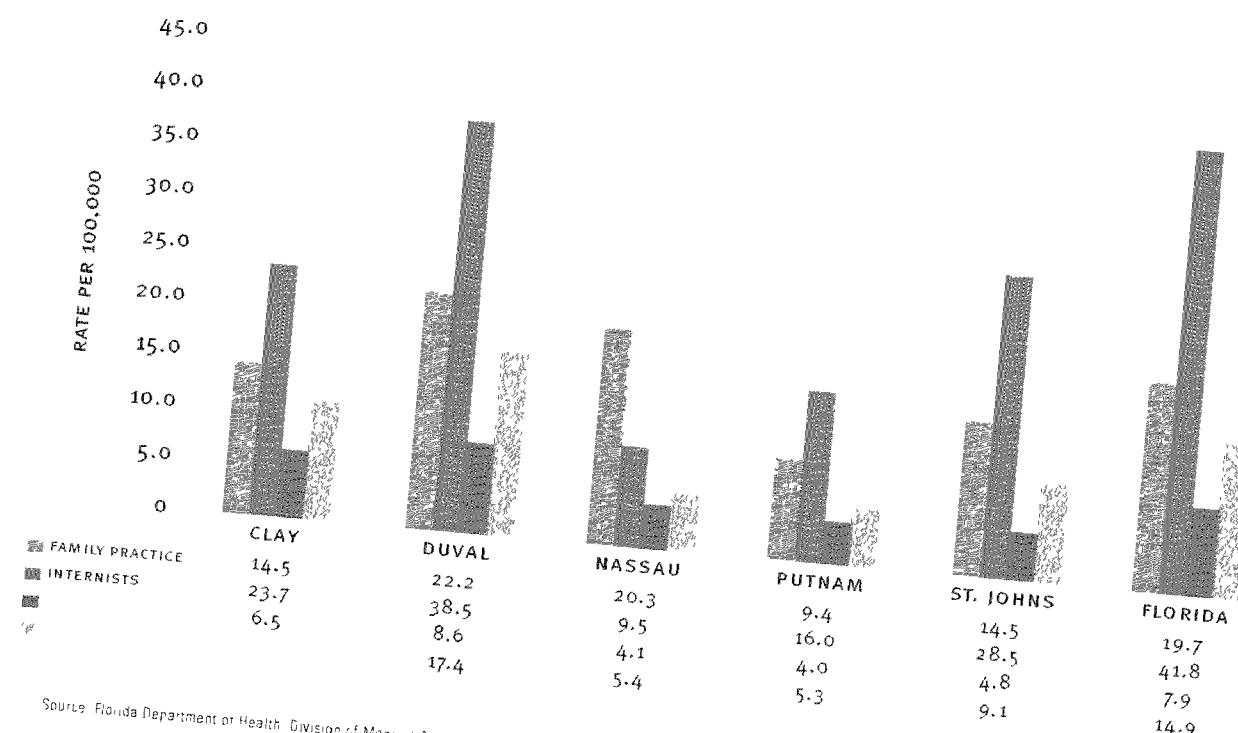


CHART 6-4 TOTAL HOSPITAL BEDS

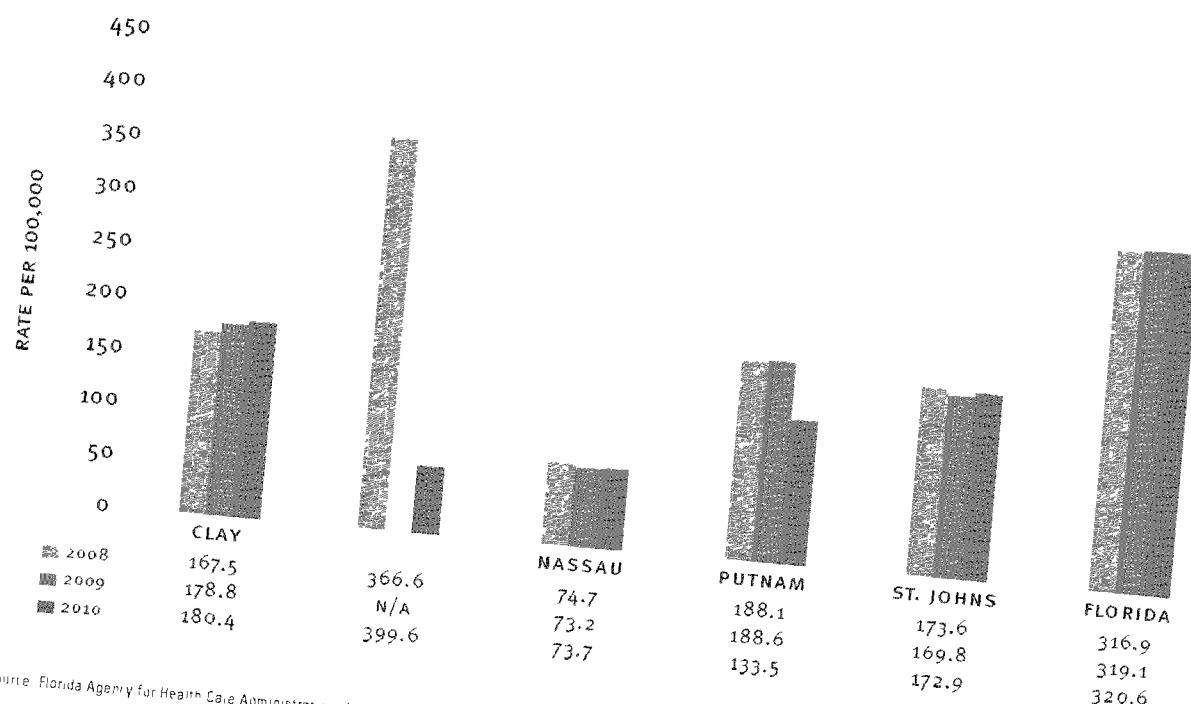
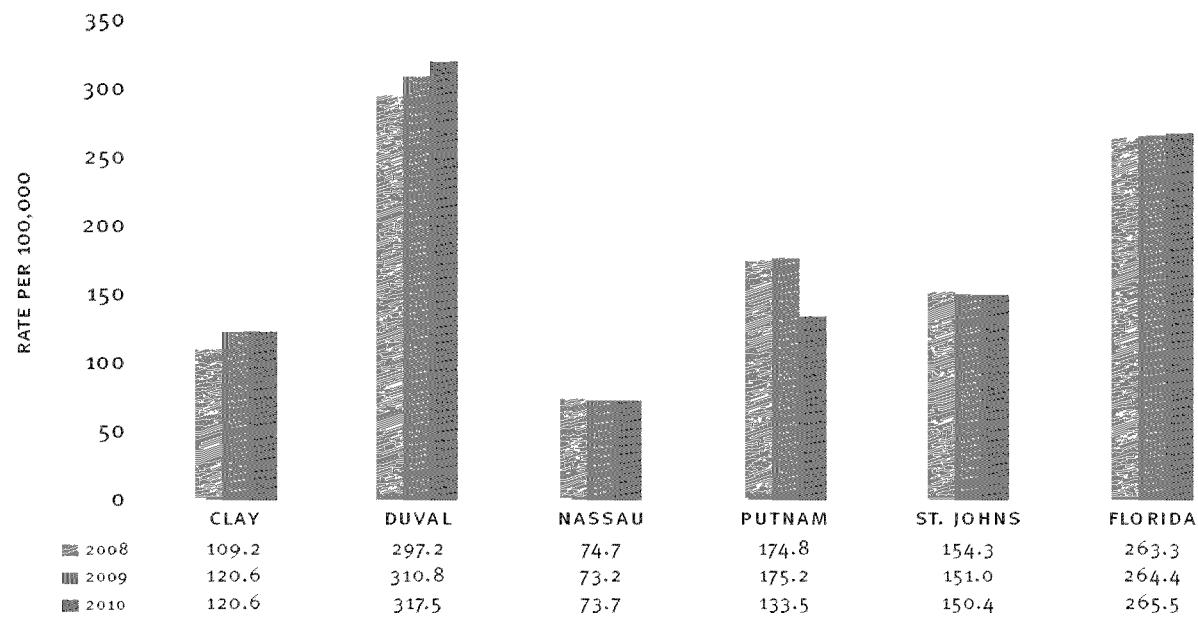
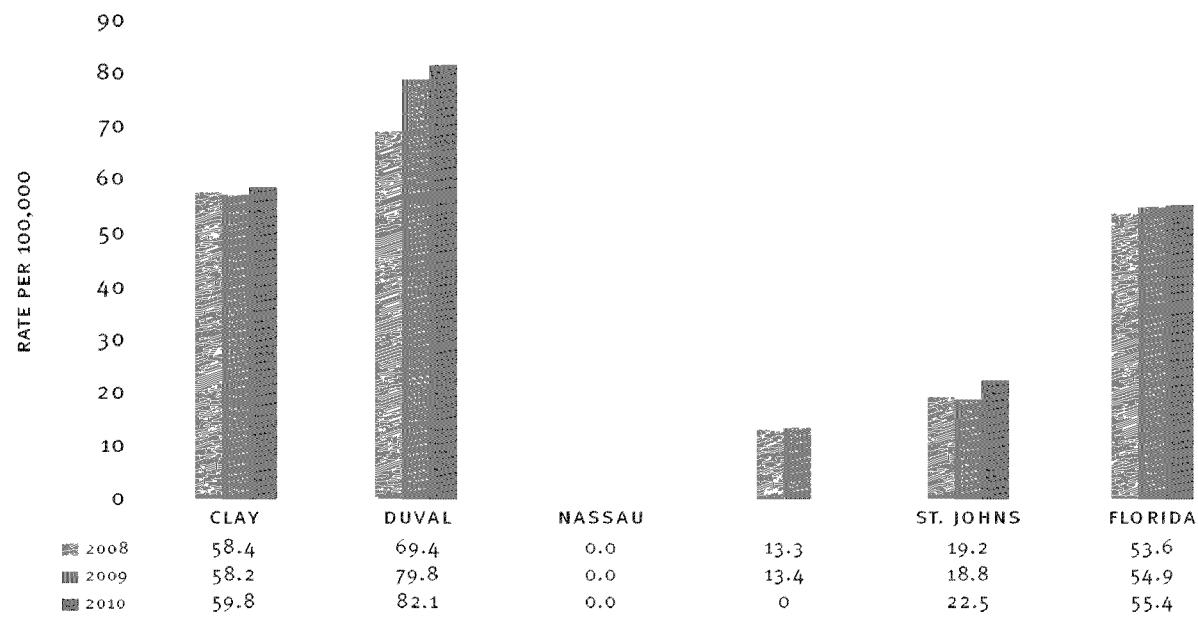


CHART 6-5 TOTAL ACUTE CARE BEDS



Source: Florida Agency for Health Care Administration (AHCA)

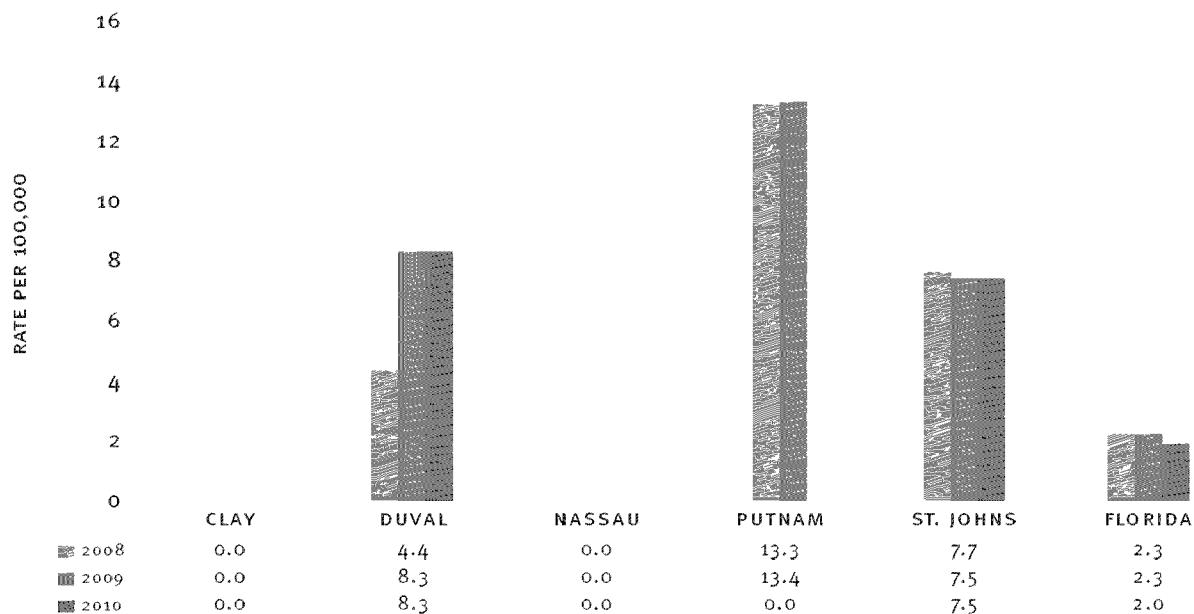
CHART 6-6 TOTAL SPECIALTY BEDS



Source: Florida Agency for Health Care Administration (AHCA)

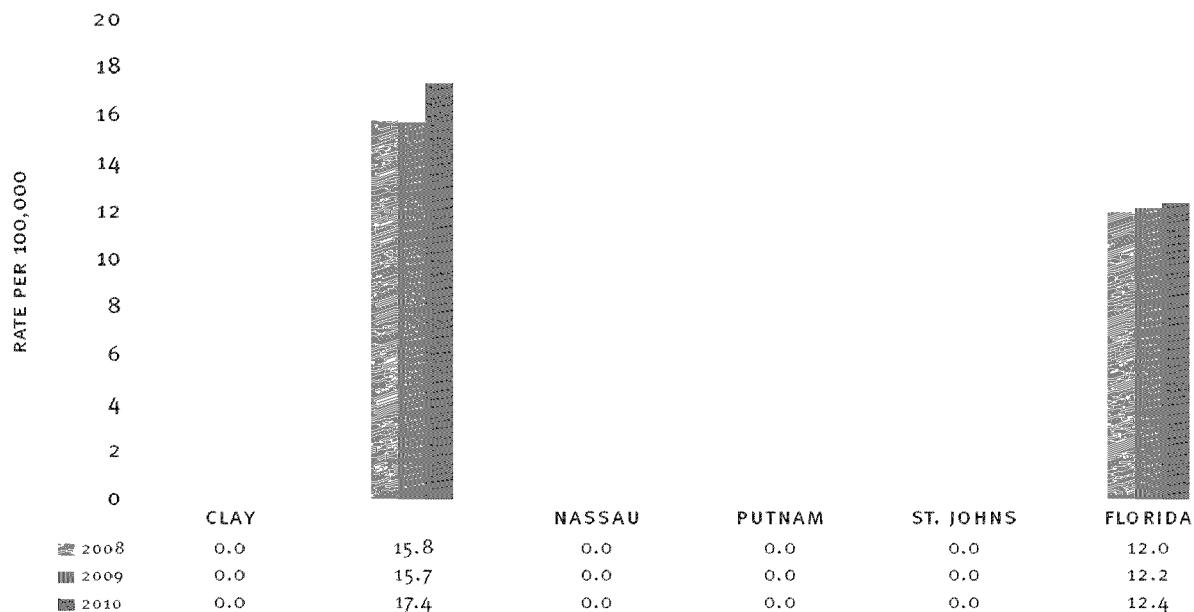
CHART 6-7

(SNU) BEDS



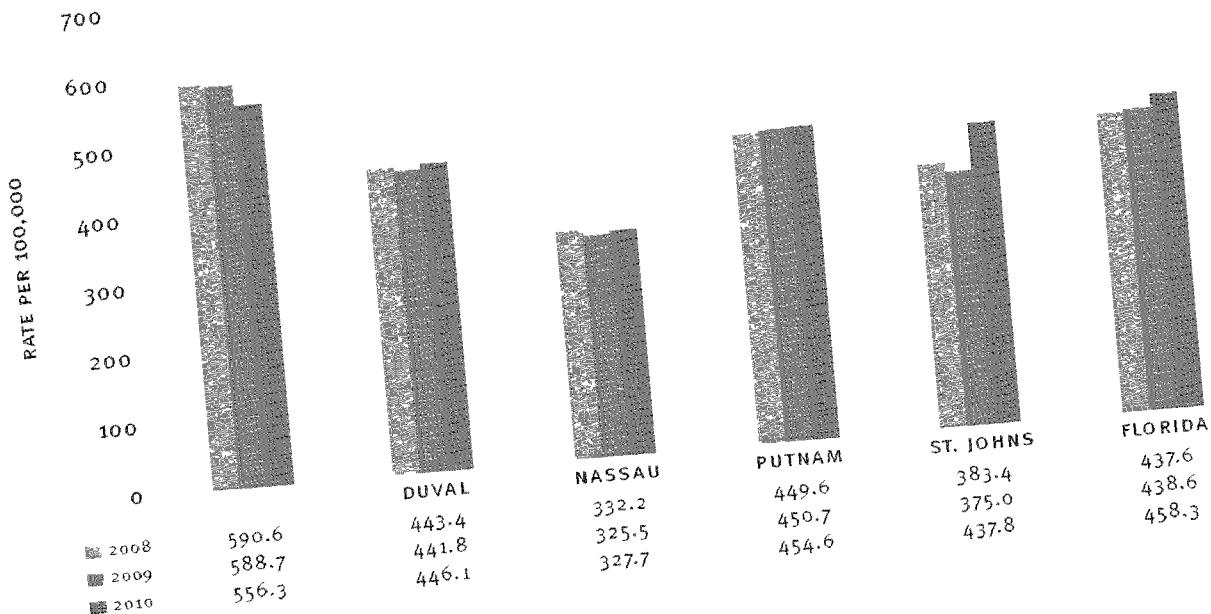
Source: Florida Agency for Health Care Administration (AHCA)

CHART 6-8 REHABILITATION BEDS



Source: Florida Agency for Health Care Administration (AHCA)

CHART 6-9 TOTAL NURSING HOME BEDS



Source: Florida Agency for Health Care Administration (AHCA)

HEALTH INSURANCE

Health care insurance coverage is critical to accessing medical care within the U.S. health care system. Coverage options vary dramatically in terms of which services are covered, which providers are covered, and what portion of the cost is the responsibility of the patient. As the national economic climate continues to fluctuate and costs of health care remain high, individuals and families are struggling to pay for adequate health care services. Most have health coverage through an employer (their own or their spouse's) or receive benefits through Medicaid or Medicare.

Hospital services are known to be extremely expensive, making health insurance coverage almost a necessity when seeking acute care services.

According to the Community Health Survey, 92 percent of households have at least one member covered by any form of insurance or health plan. When asked why no one in their household had some form of insurance, 69 percent said that it was because they can't afford the cost of insurance. Thirty-eight percent gave unemployment as the reason. Additionally, 11 percent can't buy insurance due to a pre-existing condition.

Fifty-one percent of respondents said their household's health care coverage comes from their own employer health insurance. Twenty-five percent utilize any kind of government-assistance health care coverage. The third most frequent source of health care coverage is from another family member's job (24 percent).

Sixty-two percent of respondents have insurance that covers behavioral health services. It is important to note that 31 percent of respondents answered "not sure."

Sixty-seven percent of respondents have dental insurance coverage.

Medicare and Medicaid

Medicare is provided to people ages 65 and older, some disabled people under the age of 65, and people of all ages with end-stage renal disease (permanent kidney failure treated with dialysis or a transplant). Charts 6-13 and 6-14 provide summaries of the Medicare beneficiaries and Medicare Advantage (MA) enrollees living in the five-county assessment area, which includes the private health plans such as HMOs, PPOs, and Private Fee for Service (PFFS) plans contracted to provide Medicare services. Chart 6-10 depicts the median monthly Medicaid enrollment for the five assessment counties and Florida.

Florida KidCare

Federal government provisions for children's health coverage include Medicaid and Title XXI of the Social Security Act. The states use Title XXI block grants to fund child health care coverage through an expansion of the Medicaid program, health insurance or a combination of the two. The KidCare Act of 1997 expanded Medicaid eligibility and the Healthy Kids Program, and initiated the MediKids program. Currently, there are four KidCare programs available to augment health care for children (listed below). Enrollment data are provided in Table 6-5.

- **Healthy Kids Program** – The Healthy Kids Program provides subsidized health insurance for children ages five through 18 who reside in households where income is between 100 to 200 percent of the federal poverty level (FPL). Full-pay options are also available to families with incomes above 200 percent of FPL.
- **MediKids** – MediKids covers children ages one through four with income levels at 133 to 200 percent of FPL.
- **Children's Medical Services (CMS)** – CMS covers children from birth through age 18 who have special behavioral or physical health needs or chronic medical conditions.
- **Medicaid** – Medicaid provides health insurance for children from birth through age 18, with eligibility based on the age of the child and household income. Children under the age of one are covered, if the household income is below 200 percent of FPL, children ages one through four, if the household income is less than 133 percent of FPL, and children ages six through 19, if household income is below 100 percent of FPL.

Key Findings:

- Overall, the vast majority of residents living in the five assessment counties have some form of health insurance.
- According to the Community Health Survey, 92 percent of households have at least one member covered by any form of insurance or health plan. When asked why no one in their household had some form of insurance, 69 percent said that it was because they can't afford the cost of insurance. Thirty-eight percent gave unemployment as the reason. Additionally, 11 percent can't buy insurance due to a pre-existing condition.
- Fifty-one percent of respondents said their household's health care coverage comes from their own employer health insurance. Twenty-five percent utilize any kind of government assistance health care coverage. The third most frequent source of health care coverage is from another family member's job (24 percent).
- The total number of children enrolled in KidCare in the assessment counties is considerably lower than the state average.

TABLE 6-1 HEALTH INSURANCE COVERAGE BY AGE

	CLAY	DUVAL	NASSAU	PUTNAM	ST. JOHNS	FLORIDA	U.S.
TOTAL	86.5	82.7	85.7	80.4	86.8	78.7	84.5
UNDER 18	94.4	90.2	90.6	87.6	89.0	87.3	92.0
18 - 44	77.4	73.0	71.6	64.4	79.3	61.5	74.0
45 - 64	84.5	83.4	88.8	80.0	87.1	77.3	84.8
65 AND OLDER	99.4	98.2	100.0	99.2	97.7	98.6	99.0

Source: U.S. Census Bureau - 2010 American Community Survey

TABLE 6-2 PERCENT OF ADULTS WITH ANY TYPE OF COVERAGE

	CLAY	DUVAL	NASSAU	PUTNAM	ST. JOHNS	FLORIDA
ALL	88.0%	88.1%	88.8%	82.1%	92.1%	83.0%
RACE/ETHNICITY						
NON-HISPANIC WHITE	87.1%	90.0%	88.6%	82.5%	93.0%	87.3%
NON-HISPANIC BLACK	96.7%	86.4%	N/A	89.5%	N/A	76.1%
EDUCATION LEVEL						
< HIGH SCHOOL	N/A	N/A	78.3%	66.3%	N/A	64.4%
HIGH SCHOOL/GED	81.6%	88.7%	85.6%	83.0%	88.7%	76.5%
> HIGH SCHOOL	91.1%	89.8%	92.0%	87.9%	93.8%	87.9%
ANNUAL INCOME						
< \$25,000	65.8%	83.0%	78.9%	75.6%	73.6%	64.2%
\$25,001 - \$49,999	85.5%	85.0%	89.0%	87.8%	88.6%	81.7%
\$50,000 OR MORE	94.6%	96.4%	93.3%	94.4%	96.6%	95.4%

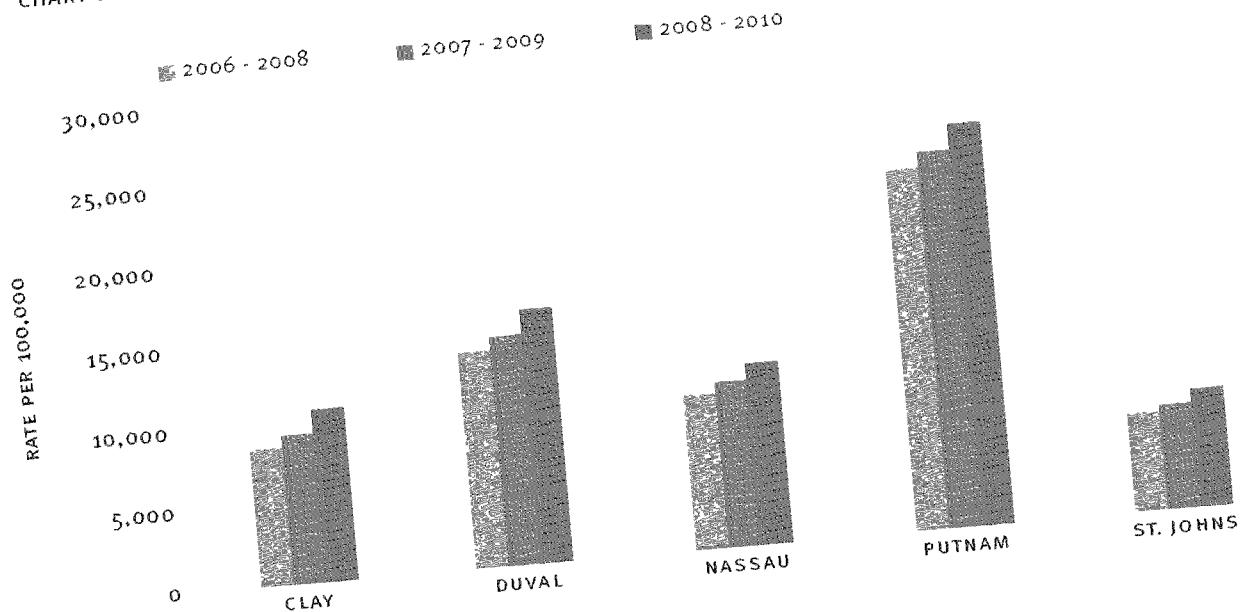
Source: Florida County Level BRPSS Survey, Florida Department of Health, Bureau of Epidemiology

TABLE 6-3 NUMBER OF ENROLLED AND PERCENT OF POPULATION

PROGRAM	CLAY	DUVAL	NASSAU	PUTNAM	ST. JOHNS	FLORIDA
MEDICARE	27,678 (14.8%)	117,639 (13.0%)	13,657 (18.5%)	16,415 (12.2%)	33,188 (17.5%)	3,390,801 (18.0%)
MEDICARE HMO	1,461 (0.8%)	15,619 (1.7%)	1,543 (2.1%)	1,113 (1.5%)	2,569 (1.4%)	804,893 (4.3%)
MEDICAID	21,758 (11.7%)	153,324 (17.0%)	8,897 (12.1%)	19,006 (25.7%)	14,561 (7.7%)	2,966,294 (15.7%)
MEDICAID HMO	11,866 (6.4%)	53,513 (5.9%)	1,934 (2.6%)	5,381 (7.3%)	62 (0.03%)	1,117,567 (5.9%)
COMMERCIAL HMO	14,119 (7.6%)	59,049 (6.5%)	5,046 (6.8%)	802 (1.1%)	10,195 (5.4%)	1,348,751 (7.2%)

Source: Florida Medical Quality Assurance (FMQA), AHCA, CMS, and Florida Demographic Estimating Conference, 2011

CHART 6-10 MEDIAN MONTHLY MEDICAID ENROLLMENT



Source: Florida Agency for Health Care Administration (AHCA)

Source: Florida Agency for Health Care Administration (AHCA)

TABLE 6-4 KIDCARE ENROLLMENT BY PROGRAM (NOT INCLUDING MEDICAID)

PROGRAM	CLAY	DUVAL	NASSAU	PUTNAM	ST. JOHNS	FLORIDA
MEDIKIDS (AGES 1-4)	234 (10.9%)	1,156 (14.3%)	67 (11.1%)	119 (14.7%)	181 (13.1%)	34,732 (12.6%)
HEALTHY KIDS (AGES 5-18)	1,682 (76.3%)	6,088 (75.3%)	462 (76.5%)	596 (73.9%)	1,076 (78%)	219,296 (79.2%)
CHILDREN'S MEDICAL SERVICES (BIRTH-18 FOR SPECIAL NEEDS)	233 (10.8%)	837 (10.4%)	75 (12.4%)	92 (11.4%)	123 (8.9%)	22,692 (8.2%)
TOTAL ACTIVE CHILDREN	2,149	8,081	604	807	1,380	276,720

Source: Florida Agency for Health Care Administration (AHCA)

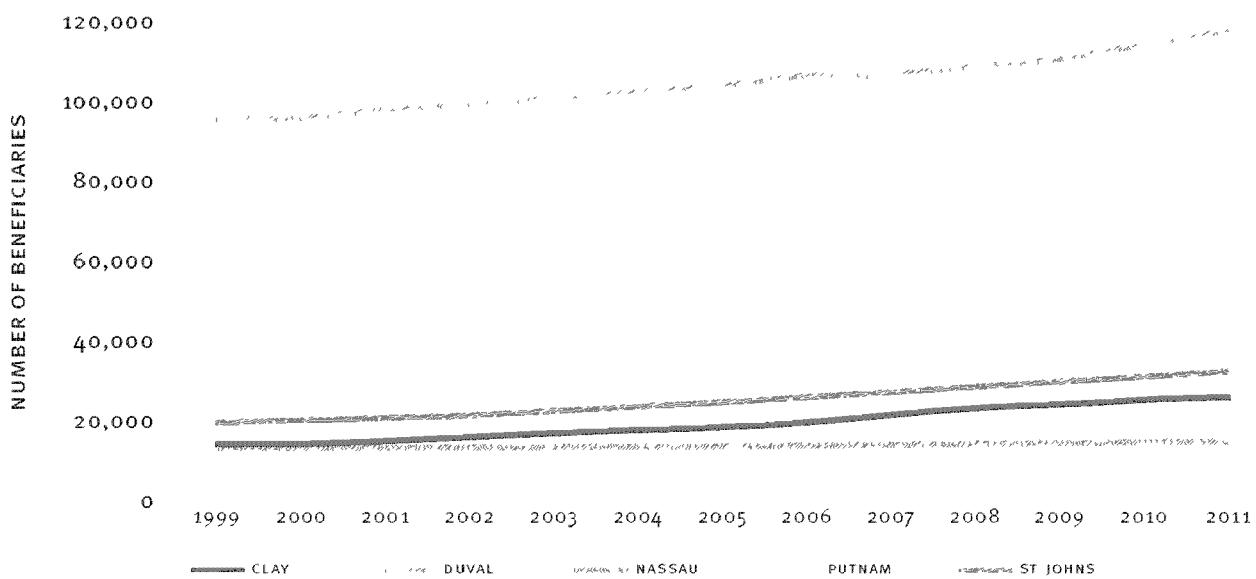
Source: Florida Agency for Health Care Administration (AHCA)

CHART 6-11 KIDCARE ENROLLMENT – MEDIKIDS AND MEDICAID, CHILDREN UNDER AGE 5



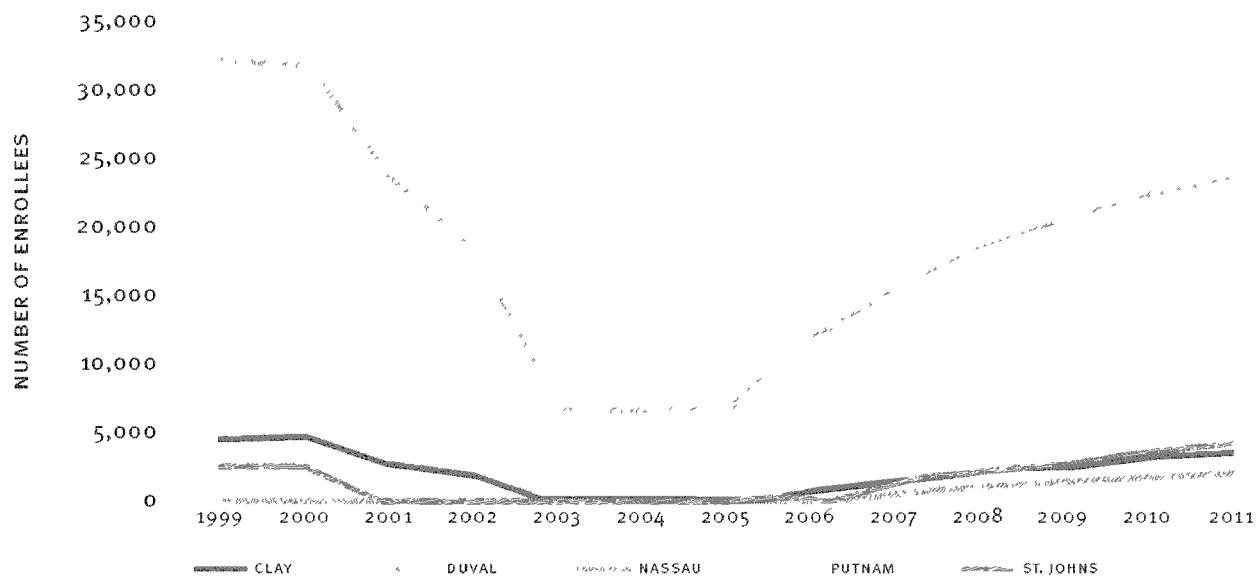
Source: Florida Agency for Health Care Administration (AHCA)

CHART 6-12 TOTAL NUMBER OF MEDICARE BENEFICIARIES



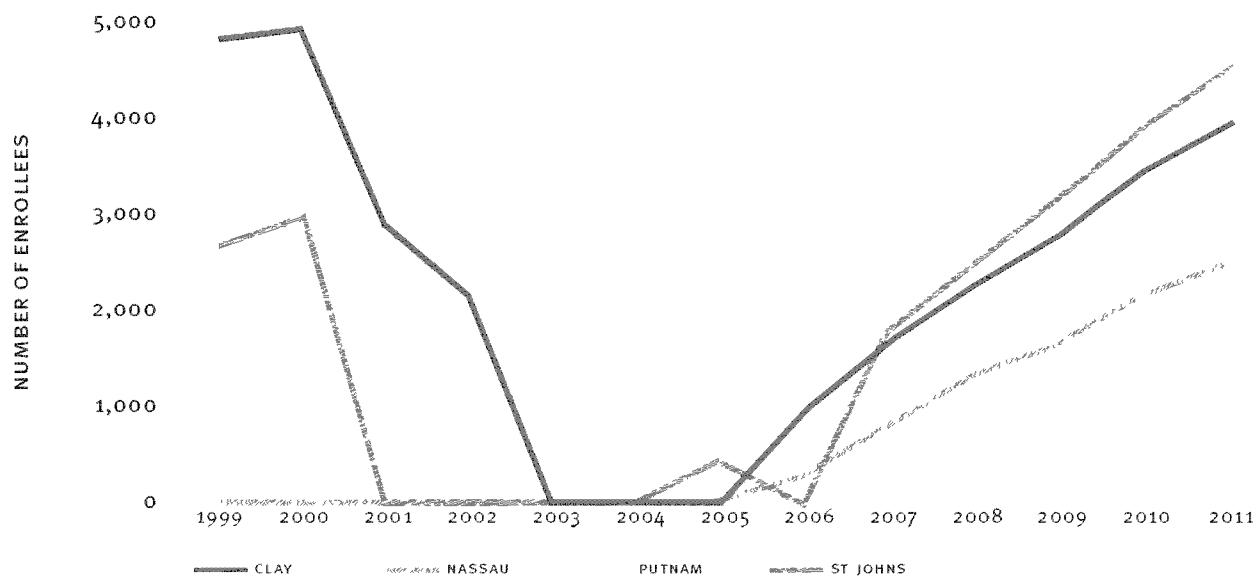
Source: Centers for Medicare and Medicaid Services (CMS), Kaiser Family Foundation

CHART 6-13 NUMBER OF MEDICARE



Source: Centers for Medicare and Medicaid Services (CMS), Kaiser Family Foundation

CHART 6-14 NUMBER OF MEDICARE ADVANTAGE ENROLLEES (WITHOUT DUVAL)



Source: Centers for Medicare and Medicaid Services (CMS), Kaiser Family Foundation

EMERGENCY DEPARTMENT VISITS

Local hospital Emergency Department (ED) utilization can be a good indicator of the availability and accessibility of area health care services. Equally important, is the patient's payor source when visiting an emergency room (ER). Chart 6-16 provides insight into the diversity of inpatient (ER admissions) ER payor source in each of the counties targeted in this community needs assessment.

Of all of the residents visiting an ER in the assessment region, at least 30 percent and no more than 35 percent are self-pay. Approximately 36 percent have Medicare or Medicaid.

Nassau County has the most self-pay and Clay County has the fewest self-pay.

In Putnam County, approximately 45 percent of all hospital inpatient visits were from Medicare beneficiaries and 19 percent were Medicaid beneficiaries. Outpatient ER payor source reveals that at least 36 percent of all patients have Medicare, Medicare HMO, Medicaid or Medicaid HMO. A minimum of 30 percent of all outpatient visits are self-pay.

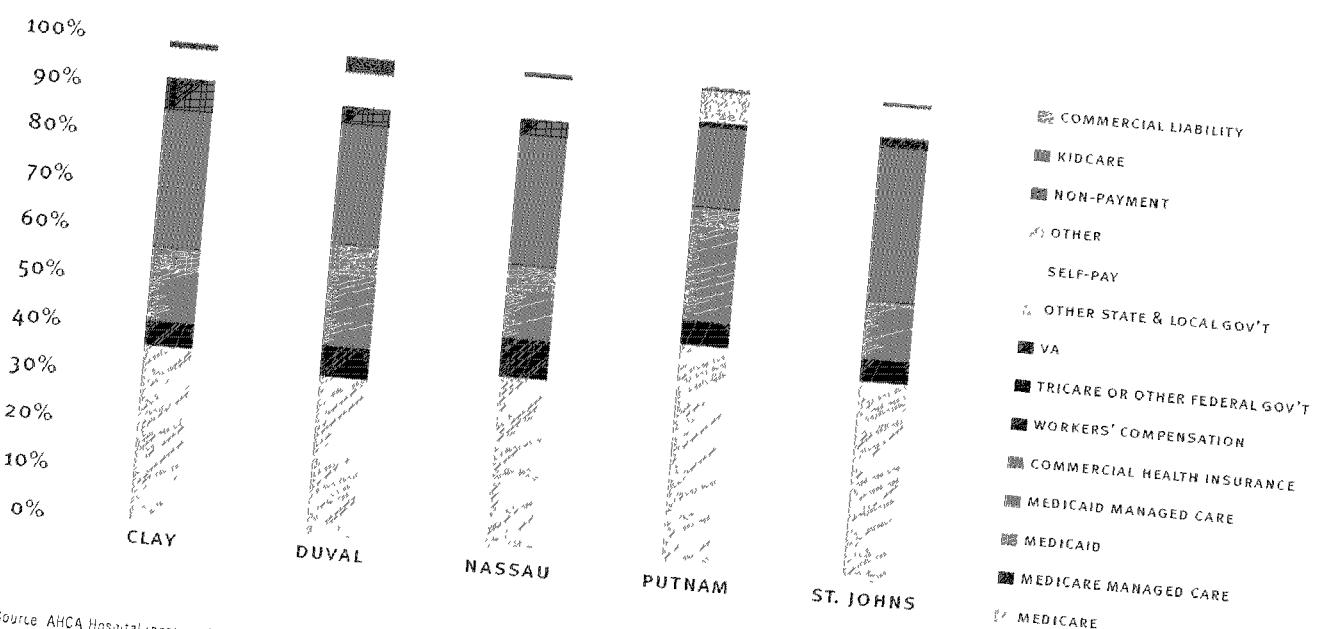
Payor source characteristics for ER visits for children look considerably different compared to adults visiting the ER. Of all of the children visiting an ER in the assessment region, at least 10 percent and no more than 15 percent are self-pay. However, a minimum of 45 percent (St. Johns County) and a maximum of 75 percent (Putnam County) of all children visiting an ER have some form of Medicaid. More children have commercial insurance compared to adults. Nassau County has the most self-pay and Putnam County has the fewest self-pay.

Finally, the Community Health Survey revealed the top three most utilized 50 percent of adult respondents, or their household members, used a hospital ER, outpatient testing or treatment was utilized by 45 percent of respondents or a household member, the third most frequent response was admittance to a hospital (41 percent).

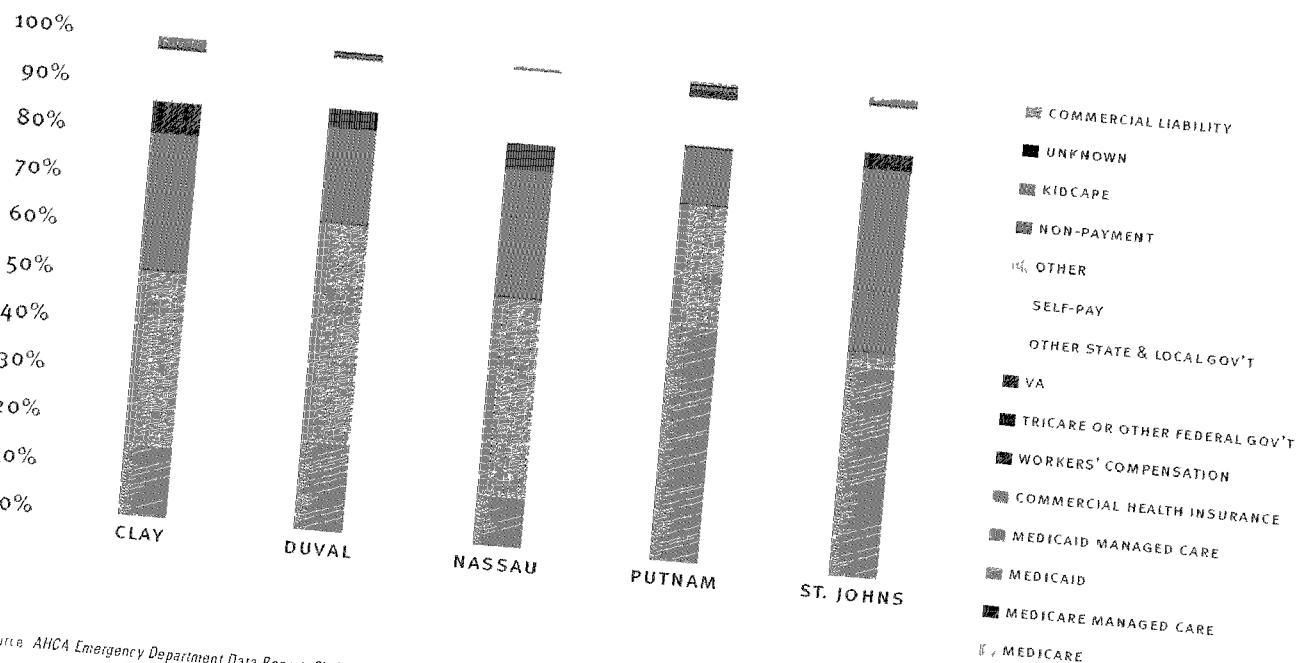
Key Findings

- Of all of the residents visiting an ER in the assessment region, at least 30 percent and no more than 35 percent are self-pay. Approximately 36 percent have Medicare or Medicaid. Only 27 percent of ER patients have commercial insurance. Nassau County has the most self-pay and Clay County has the fewest self-pay.
- In Putnam County, approximately 45 percent of all hospital inpatient visits were from Medicare beneficiaries and 19 percent were Medicaid beneficiaries. Outpatient ER payor source reveal that at least 36 percent of all patients have Medicare, Medicare HMO, Medicaid or Medicaid HMO.
- Payor source characteristics for children's ER visits look considerably different compared to adults visiting the ER. Of all of the children visiting an ER in the assessment region, at least 10 percent and no more than 15 percent are self-pay. However, a minimum of 45 percent (St. Johns County) and a maximum of 75 percent (Putnam County) of all children visiting an ER have some form of Medicaid. More children have commercial insurance compared to adults. Nassau County has the most self-pay and Putnam County has the fewest self-pay.

CHART 6-15 HOSPITAL INPATIENTS PAYOR SOURCE

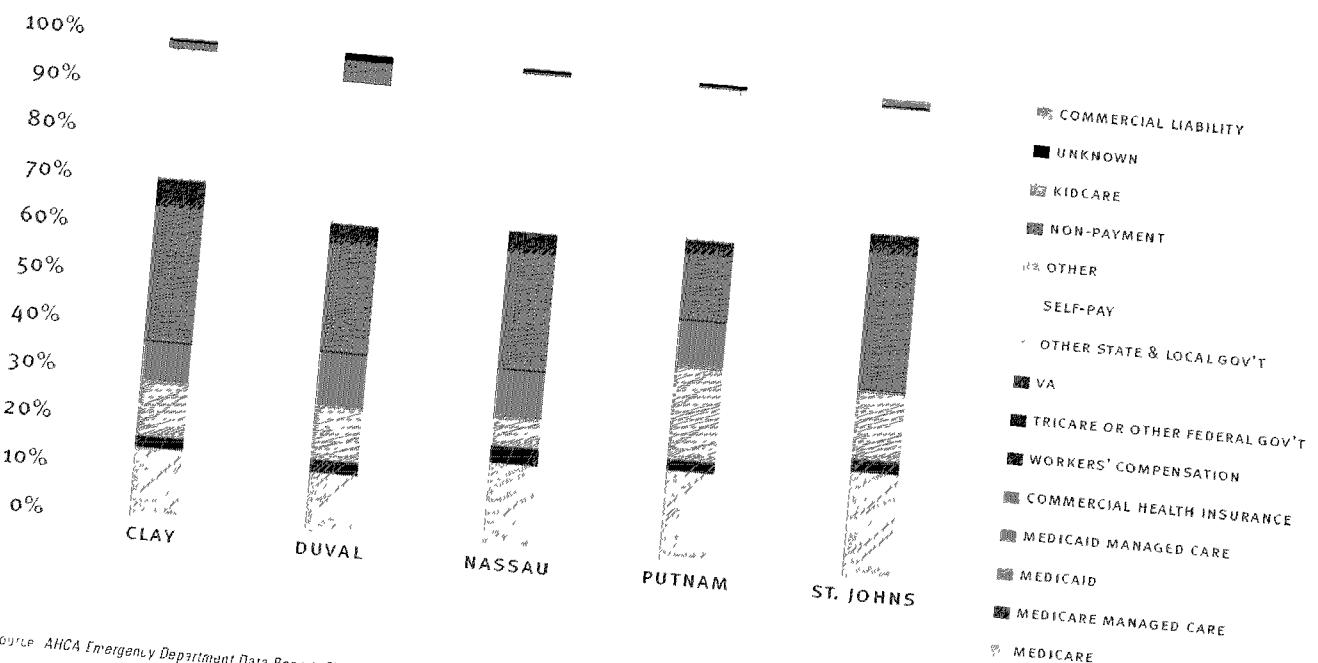


Source: AHCA Hospital Inpatient Data CV 2010

CHART 6-16 OUTPATIENT ED VISITS BY PAYOR SOURCE
PEDIATRICS AGES 17 AND UNDER

Source: AHCA Emergency Department Data Report CV 2010

CHART 6-17 OUTPATIENT ED VISITS BY PAYOR SOURCE
AGES 18 AND OLDER



SOURCE: AHCA Emergency Department Data Report, CY 2010

DENTAL COVERAGE AND PROVIDER SUPPLY

During 2010 to 2011, the rate of licensed dentists per 100,000 population in all five counties was much lower than the state (Chart 6-19). Generally, access to dental care declines as income declines. While the percentage of low-income persons with access to dental care in all five counties is considered low, the percentage of low-income persons accessing dental services is above the rate for the state of Florida (Chart 6-20).

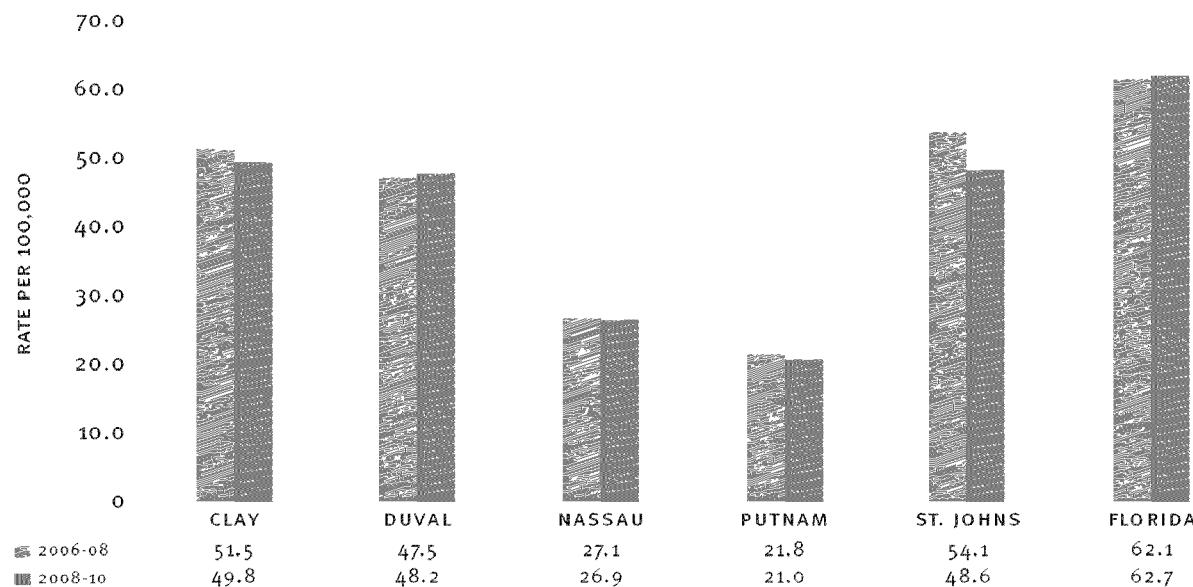
Survey respondents indicated that dental care is the third most frequently delayed service (behind "visit to doctor" and "medical test, exam or screening"). Additionally, 63 percent of respondents received a dental exam in the last 12 months. Forty-nine percent reported that their most recent visit to the dentist was within the past six months. However, 11 percent have not seen a dentist in five or more years. The same type of pattern exists for the children of respondents. The largest group of respondents answered "within the past six months" (43 percent). However, 16 percent of the respondents said their child has never visited a dentist or dental clinic.

All five counties in the assessment region are below the state average for rate of total licensed dentists. The levels have stayed about the same in all counties except for St. Johns where there was a decrease (See Chart 6-19). While the number of dentists does play a part in the accessibility of dental care, focus group participants feel that insurance coverage dictates which health services are accessible to each person, especially dentists. According to the survey data, two-thirds (67 percent) of survey respondents have dental insurance coverage. This type of coverage is likely not as common among low-income residents. Access to dental services for low-income individuals has increased marginally since 2008, except in Nassau County. Even with the decline, Nassau County's levels are still much higher than the state level. See Chart 6-20 for more information on access to dental services for low-income residents.

Key Findings:

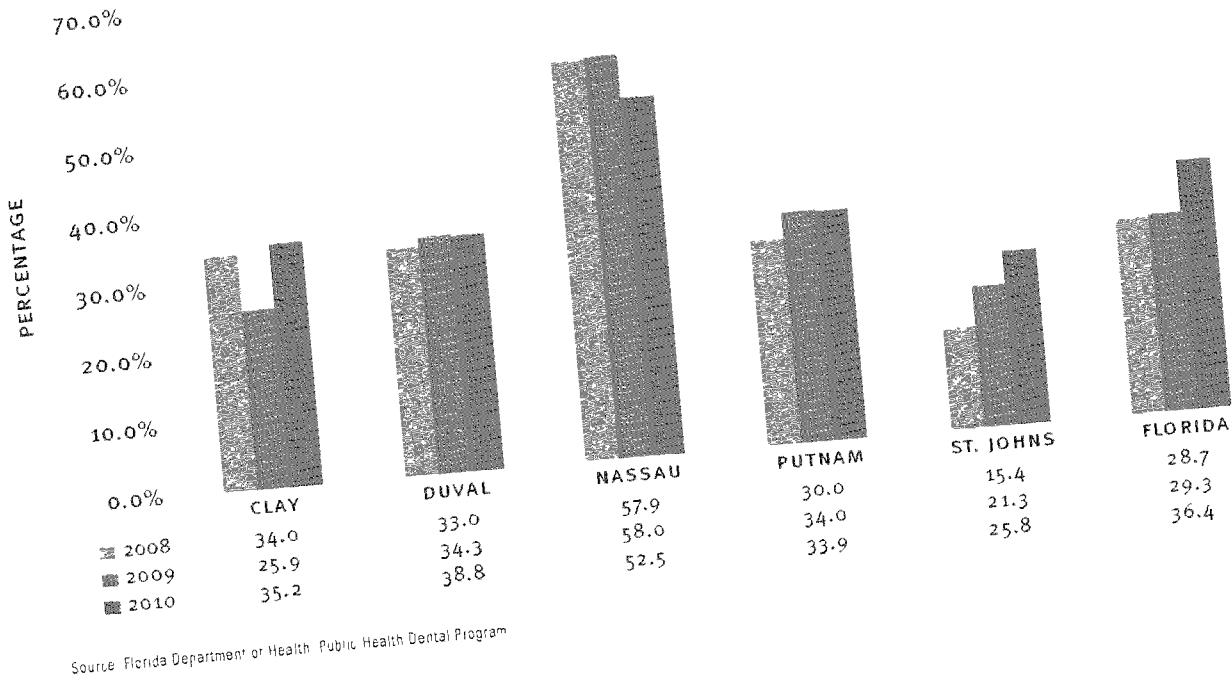
- Generally, access to dental care declines as income declines. While the percentage of low-income persons with access to dental care in all five counties is considered low, the percentage of low-income persons accessing dental services is higher than the state of Florida's percentage
- Survey respondents indicated that dental care is the third most frequently delayed service (behind "visit to doctor" and "medical test, exam or screening")
- 11 percent of the survey respondents have not seen a dentist in five or more years
- While the number of dentists does play a part in the accessibility of dental care, focus group participants feel that insurance coverage dictates which health services are accessible to each person, especially dentists
- According to the survey data, two-thirds (67 percent) of survey respondents have dental insurance coverage

CHART 6-18 TOTAL LICENSED DENTISTS



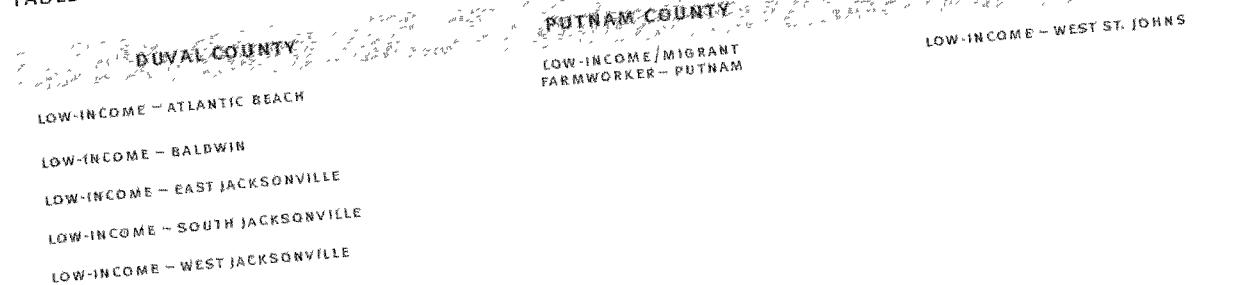
Source: Florida Department of Health Division of Medical Quality Assurance

CHART 6-19 ACCESS TO DENTAL CARE BY LOW-INCOME PERSONS



Source: Florida Department of Health Public Health Dental Program

TABLE 6-5 DESIGNATED HEALTH PROFESSIONAL SHORTAGE AREAS (HPSA)



Source: HRSA Dental Care HPSAs Designated on 08/01/2011

HEARING AND VISION PROVIDER SUPPLY

Focus group participants did not mention difficulty in receiving hearing or vision services. However, the most commonly delayed test or exam among survey respondents was an eye exam (44 percent). On the other hand, 62 percent had received an eye exam in the last 12 months.

See

Tables 6-7 and 6-8 for the numbers of vision and hearing practitioners in each county

TABLE 6-6 NUMBER OF PRACTITIONERS AND OFFICES

	CLAY	DUVAL	NASSAU	PUTNAM	ST. JOHNS
OPTOMETRIST	32	137	10	3	40
OPTICIAN	50	121	9	12	50
OPTICAL ESTABLISHMENT PERMIT	15	58	2	3	3
OPTOMETRY BRANCH OFFICE	14	38	0	8	19

Source: Florida Department of Health License Verification

TABLE 6-7 NUMBER OF AUDIOLOGISTS

	CLAY	DUVAL	NASSAU	PUTNAM	ST. JOHNS
	9	51	5	2	21

Source: Florida Department of Health License Verification

BARRIERS TO CARE

Affordability

Affordability and time constraints were two common barriers mentioned in the focus groups. The economy has led to many people losing their jobs and, in turn, their health benefits. Aside from job loss, coverage is decreasing while premiums and co-pays are on the rise, as well as the cost of prescription medication. In the survey, for the eight percent of uninsured households (determined by answers to question 17), 69 percent said that it was because they can't afford the cost of insurance and 38 percent gave unemployment as the reason. As one participant said, "Without health insurance, it is difficult to get services unless you go to the emergency room." Of those survey respondents who stated they had delayed health care services, the three most frequently noted reasons for delaying health care treatment were "inability to pay" (38 percent), "no insurance" (35 percent) and "concerned about spending in current economy" (33 percent). As people attempt to compensate for the dismal economy, dual-income families are becoming more common. But in dual-earner families, finding time to get to the doctor is difficult.

Transportation as a Barrier

A common theme in the focus groups was the challenges presented by a lack of transportation, especially when trying to obtain health care. A handful of participants mentioned that transportation needs extend beyond getting to and from medical centers, but that is all the public transportation assists them with. Upon initial evaluation of the survey data, it seems that access to public transportation is not as important as many of the other attributes of a healthy community. However, when the crosstabs were analyzed, it became evident that while it isn't important for everyone, it is very important for some.

Additionally,

As

might be expected, the importance placed on access to public transportation decreases overall with rise in income.

Key Findings:

- Affordability (a barrier to care) plays a role in the decisions that residents make to take care of their health, of those survey respondents who stated they had delayed health care services, the three most frequently noted reasons for delaying health care treatment were “inability to pay” (38 percent), “no insurance” (35 percent) and “concerned about spending in the current economy” (33 percent)
- A common theme in the focus groups was the challenges presented by a lack of transportation, especially when trying to obtain health care. A handful of participants mentioned that transportation needs extend beyond getting to and from medical centers, Upon initial evaluation of the survey data, it seems that access to public transportation is not as important as many of the other attributes of a healthy community. However, when the crosstabs were analyzed, it became evident that while it isn’t important for everyone, it is very important for some
- The importance placed on access to public transportation decreases overall with a rise in income. The importance is highest for those making less than \$15,000 (96 percent) and lowest for those making \$100,000 or more (70 percent)

CAREGIVERS¹²

Additional help with caregiving (at all stages of disease) is the greatest need for caregivers. There seems to be confusion among caregivers as to what resources are available to them, and how to secure and/or qualify for the resources. This does not seem to be as much of an issue in the earlier stages of disease. Caregivers have difficulty asking for help, particularly in the early stages of the disease. They often do not ask for help until an emergency situation arises. When physicians use the term Alzheimer’s, all agreed that seeking help seems easier. Overnight help, while sometimes available, did not seem to be a high priority with caregivers. Many caregivers believe that leaving their spouse or parent overnight is not worth it because of the setbacks they often experience. Additional daycare hours would be used. Participants mentioned drop-in care, late afternoon hours and early evening hours as being very beneficial. Participants discussed starting mini-support groups or informal get-togethers with caregivers and their loved ones.

Spouses and children often become caregivers out of necessity. Many quit jobs and move. Many caregivers have financial problems because of these unexpected changes.

Caregivers want more information from doctors. Some doctors don’t provide even basic information and resources. Dental problems were identified as the major health problem, particularly with patients whose disease was more progressed. The patient tends to be non-cooperative, not liking someone in their mouth. Preventive dental care is difficult for caregivers. Dental care is expensive, many dentists don’t accept Medicaid.

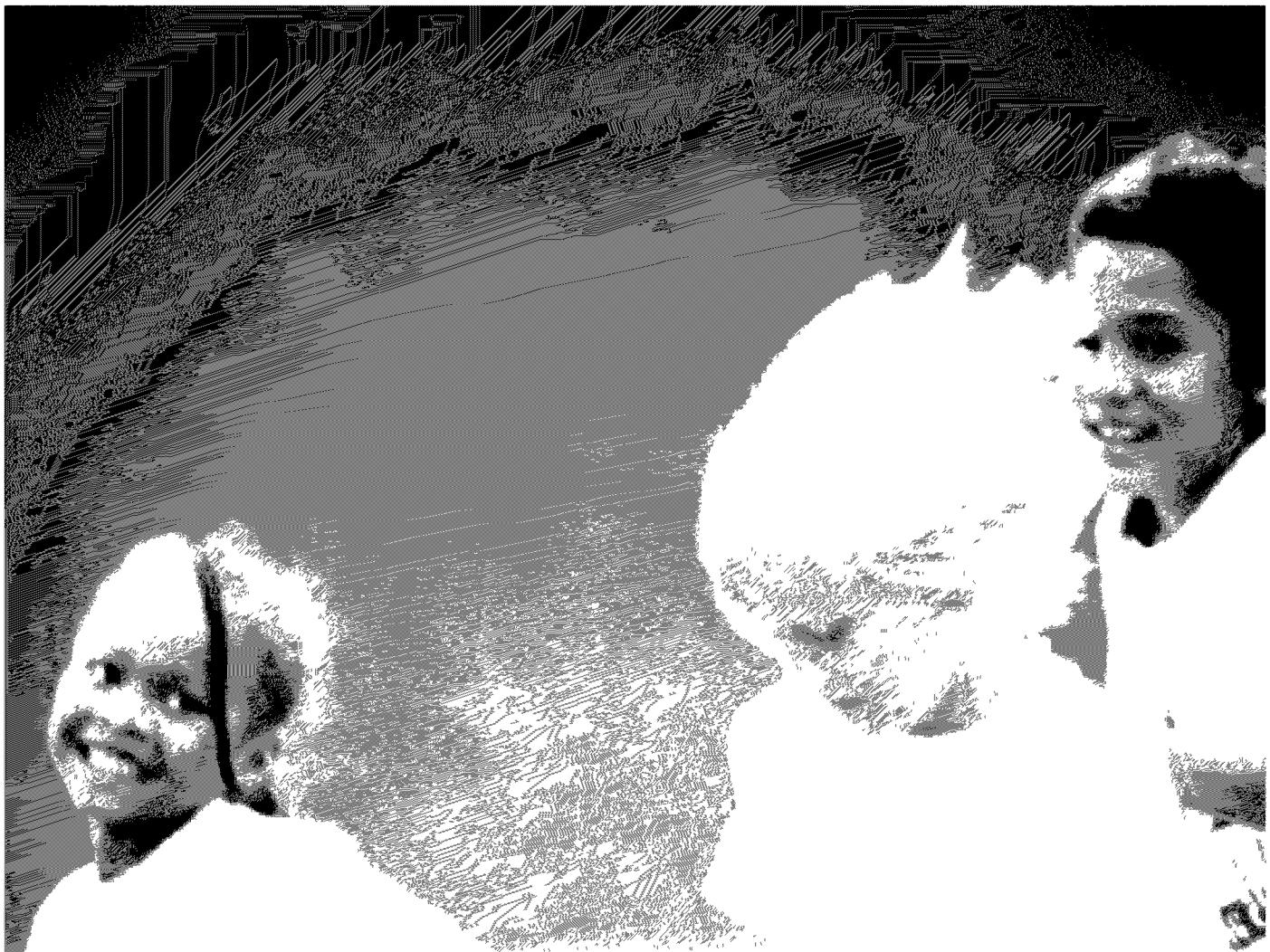
Caregivers have difficulty staying healthy. Injuries suffered when transporting their loved ones are common. In addition, many caregivers, particularly those with loved ones who are newly diagnosed, suffer from issues of fear and guilt. Many caregivers don’t have the time or finances to take care of their own health.

Children of caregivers play varying roles in helping a parent provide care, depending on where they live, their job and family responsibilities, etc. Children do not always understand the severity of a parent’s disease. Caregivers are hesitant to ask their children for help, they would be more willing to ask for help if they could pay their child.

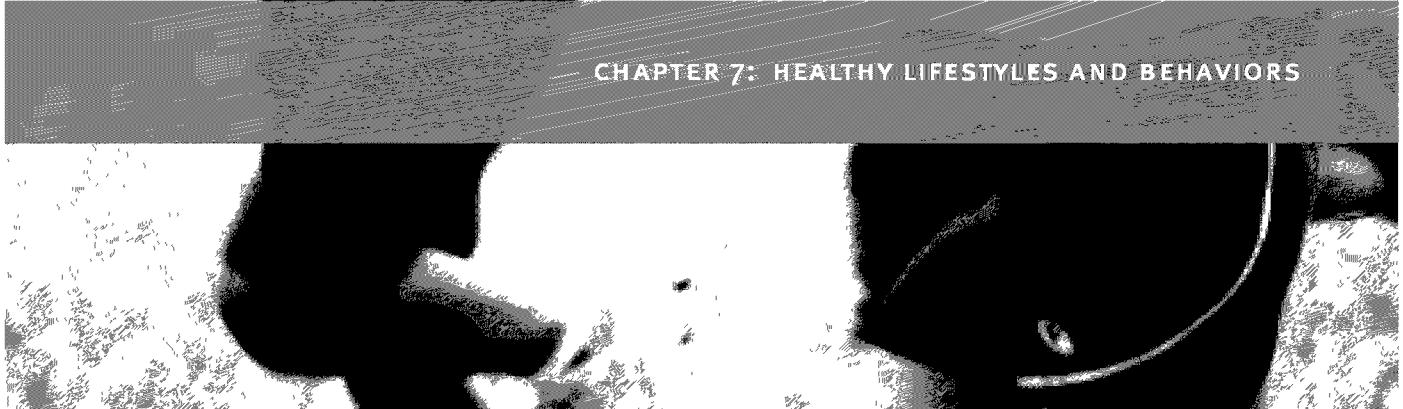
¹² The information on caregivers comes from caregiver focus groups conducted by The Health Planning Council in 2011 for another assessment.

Key Findings:

- Participants mentioned drop-in care, late afternoon hours and early evening hours as being very beneficial
- Participants discussed starting mini-support groups or informal get-togethers with caregivers and their loved ones
- Dental problems were identified as the major health problem, particularly with patients whose disease was more progressed. The patient tends to be non-cooperative, not liking someone in their mouth. Preventive dental care is difficult for caregivers. Dental care is expensive; many dentists don't accept Medicaid



CHAPTER 7: HEALTHY LIFESTYLES AND BEHAVIORS



PHYSICAL ACTIVITY

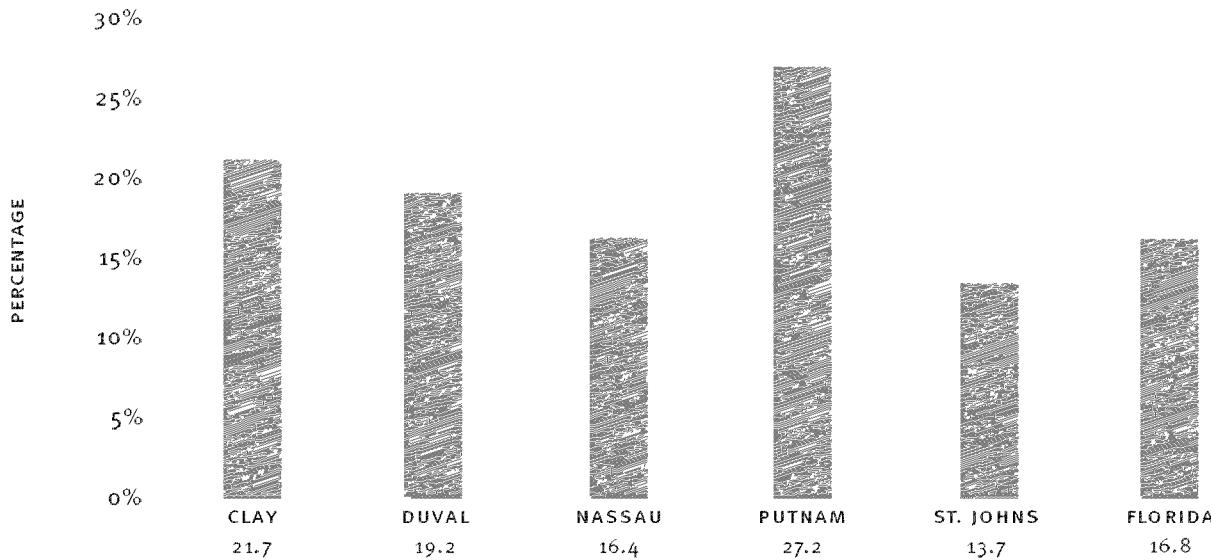
It is well known that regular physical activity can help people manage their weight as well as reduce their risk for chronic disease. However, most people do not get the recommended amount of daily activity. According to guidelines set by the Centers for Disease Control and Prevention, children and adolescents should get 60 minutes or more of physical activity per day, and adults 18 years and older should get 150 minutes of physical activity per week.

For some, physical barriers (i.e., disability, injury) or behavioral health difficulties make physical activity challenging. This is the case for more than 25 percent of Putnam County residents. The percentages in Clay and Duval Counties lie above the state average of 16.8 percent. St. Johns County residents have the least amount of challenges in this area. (See Chart 7-1 for details.) Physical activity among youth is a salient topic, with efforts such as *Let's Move* and *Play 60* receiving recognition. Despite the efforts of our nation's leaders, children still do not get the exercise they should. Chart 7-2 describes the number of students who do not get adequate exercise. Nearly 40 percent of Putnam County middle and high school students do not get enough physical activity. St. Johns County students in both middle and high school beat the state average. Refer to Chart 7-2 for further comparison.

Key Findings

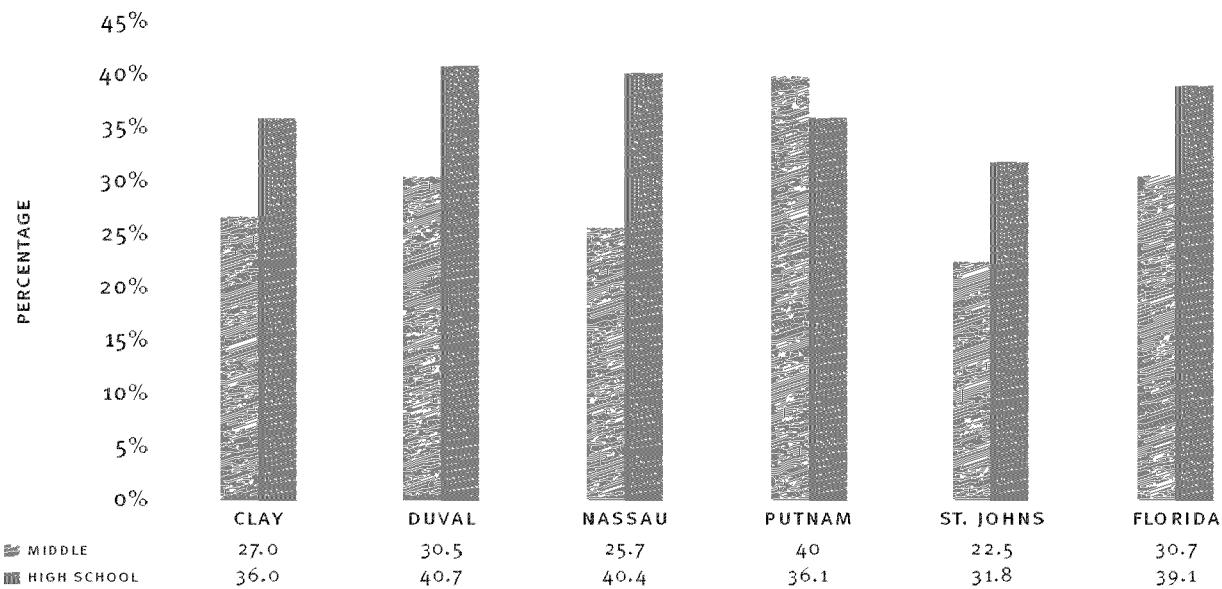
- Physical or behavioral health act as barriers to physical activity in all counties of the region, but especially in Putnam
- Children in middle and high school do not get enough physical activity, especially in Putnam County
- High school physical activity levels are low across the board

CHART 7-1 PHYSICAL OR BEHAVIORAL HEALTH AS A BARRIER TO PHYSICAL ACTIVITY



Source: 2010 Florida Behavioral Risk Factor Surveillance System (BRFSS) Data Report

CHART 7-2 STUDENTS WITHOUT SUFFICIENT PHYSICAL ACTIVITY



Source: Florida Department of Health School-aged Child and Adolescent Profile

IMMUNIZATIONS AND SCREENINGS

Secondary data analyses have concluded the following regarding immunizations and screenings, excluding vision which was primary data from respondent survey

Vision

Within the past 12 months, approximately 56 percent of Clay County respondents reported that they had delayed eye care visits, while Duval and Nassau Counties reported lower rates of 21 and 22 percent, respectively. St. Johns County reported the lowest amount at four percent.

Oral Health

Within the past year, St. Johns County had the highest percentage of White adults to visit a dentist or dental clinic at 76.9 percent, which was higher than the state rate of 68.2 percent. Putnam County demonstrated the lowest percentage of White adults at 51.2 percent and only 25.4 percent of Black adults. Clay, Duval and Nassau Counties exhibited results similar to the state percentage for White adults, but higher for Black adults in Clay and Duval Counties at 69.1 and 65.0 percent, respectively. As previously stated in this report, Nassau and St. Johns Counties have relatively small Black populations. This was represented by the lack of reportable percentages for Black adults in these counties.

The rate of adults who had permanent tooth removal due to tooth decay or gum disease was highest in Putnam County for both White and Black adults at 64.8 and 74.6 percent to the state percentage of 52.1 and 62.4, respectively. Clay, Duval, Nassau and St. Johns Counties reported lower than state percentages for White and Black adults. In parallel to this result, the percentages of adults who had their teeth cleaned in the past year was higher in these same counties.

As previously stated in this report, Nassau and St. Johns Counties have a relatively low amount of Black residents; this was represented by the lack of reportable percentages for Black adults in these counties.

Putnam and St. Johns Counties reported significant decreases for diseases of hard tissues of teeth from 2008 to 2010, while all counties reported a decrease in pediatric diseases of hard tissues of teeth. Nassau County displayed a significant decrease in adult disease of pulp and periapical tissue (down from 207 to 98 from 2008 to 2010), while Putnam County displayed a dramatic decrease in pediatric diseases of pulp and periapical tissue at the same time, dropping from 13 to four percent.

Childhood Immunizations

Rates in 2010 for immunization levels in kindergarten-aged children were, on average, higher than the state rate of 91.3 percent for Clay, Duval, Nassau and Putnam Counties. The rates for St. Johns County were slightly lower than the state rate, at 91.2. Duval marked the highest rate of 95.8 percent by comparison. St. Johns County had a high improvement between 2008 and 2010 from 88.6 to 91.2, but still remains the lowest rate for the region.

Influenza and Pneumonia

Percentages of adults ages 65 years and older who have ever received a pneumonia vaccination were comparatively lower than the state rate of 69.9 percent; excluding Nassau County at 70.8 percent and St. Johns County at 76.4 percent. Duval County demonstrated the lowest percentage (59.6 percent).

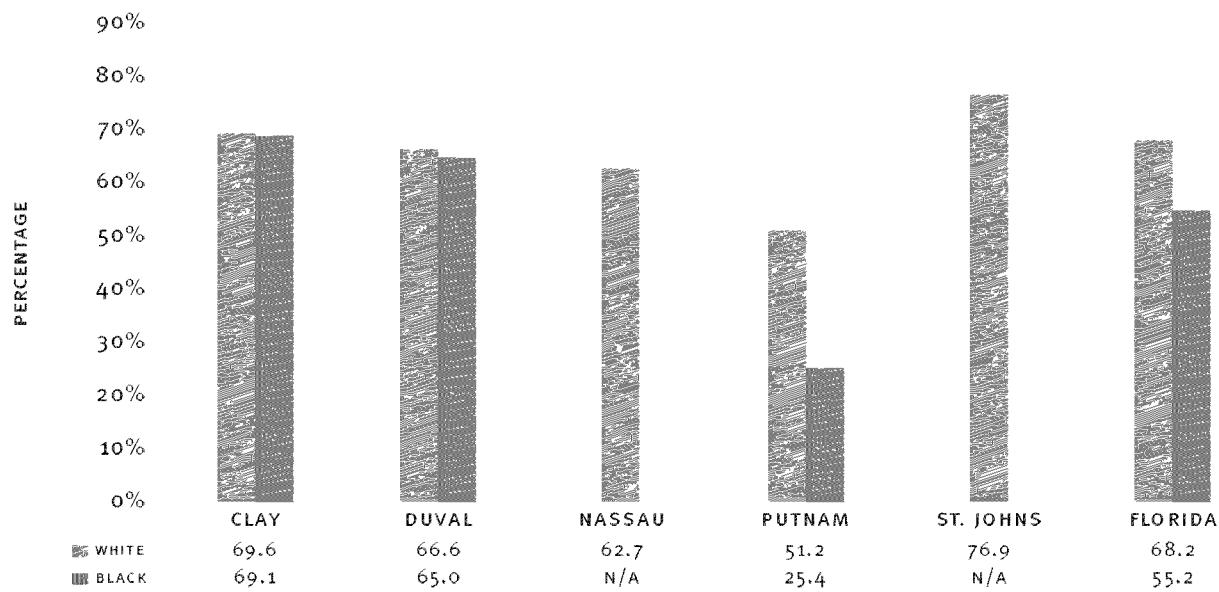
In addition, percentages of adults ages 65 years and older who received a flu shot in the past year remain close to the state percentage of 65.3 percent. Duval and Putnam Counties remain the lowest at 60.9 and 54.9 percent respectively, while St. Johns County has the highest percentage (70.1 percent).

Percentages for both vaccinations remain similar in the 65 years and older demographic for all counties. However, race had an effect, as a higher percentage of White respondents reported to have been vaccinated compared to Black and Hispanic adult respondents in all counties.

Key Findings

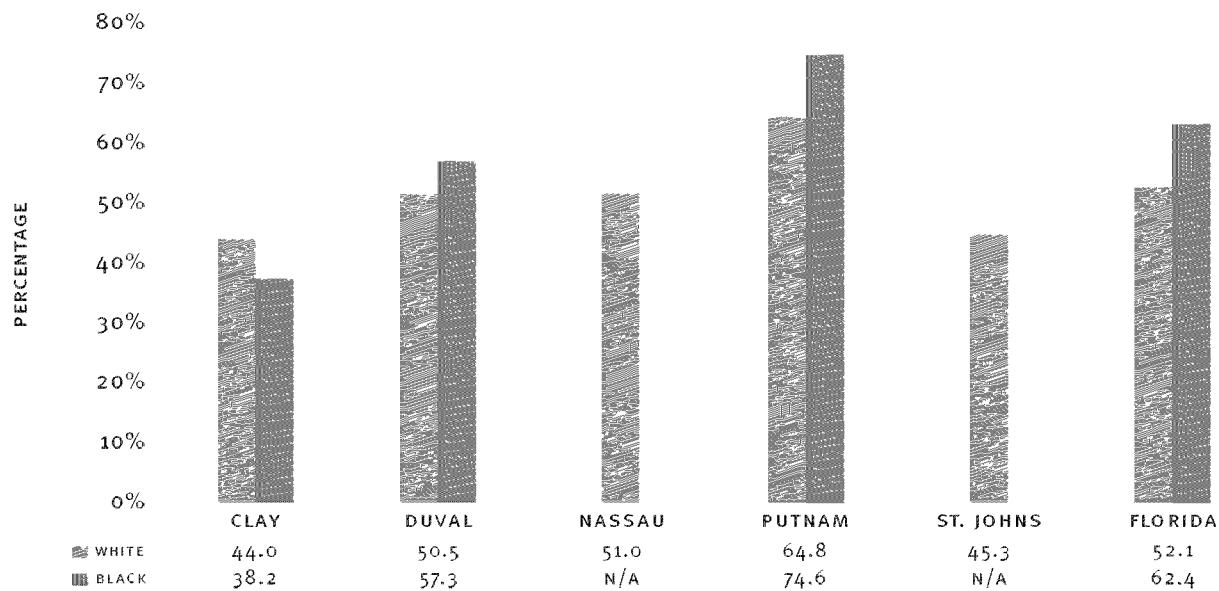
- Whites demonstrated high percentages of dental care and dental visits, while Blacks had higher percentages of tooth removal due to tooth decay and gum disease.
- Putnam County had the highest marked percentage of permanent tooth removal (because of tooth decay or gum disease) for both White and Black adult respondents, and had the lowest percentages for dental visits and teeth cleanings.
- Putnam County displayed a high rate of improvement for tooth decay and gum disease for both adults and pediatrics.
- Many of the counties displayed a decrease in dental and gum problems in 2009, but increased the following year.
- Duval marked the highest rate of immunization in kindergarten-aged children.
- St. Johns County reported an improvement for immunizations in kindergarten-aged children from 88.6 to 91.2 percent between 2008 and 2010, but continued to be the lowest rate for the region.
- Duval County demonstrated the lowest percentage of adults ages 65 years and older who have ever received a pneumonia vaccination.
- Duval and Putnam Counties had the lowest percentage of adults ages 65 years and older who have ever received a flu shot in the past year, while St. Johns County remained the highest.
- All counties reported that a higher percentage of White adult respondents are vaccinated compared to Black and Hispanic adult respondents.

CHART 7-3 PERCENTAGE OF ADULTS WHO VISITED A DENTIST OR DENTAL CLINIC IN THE PAST YEAR



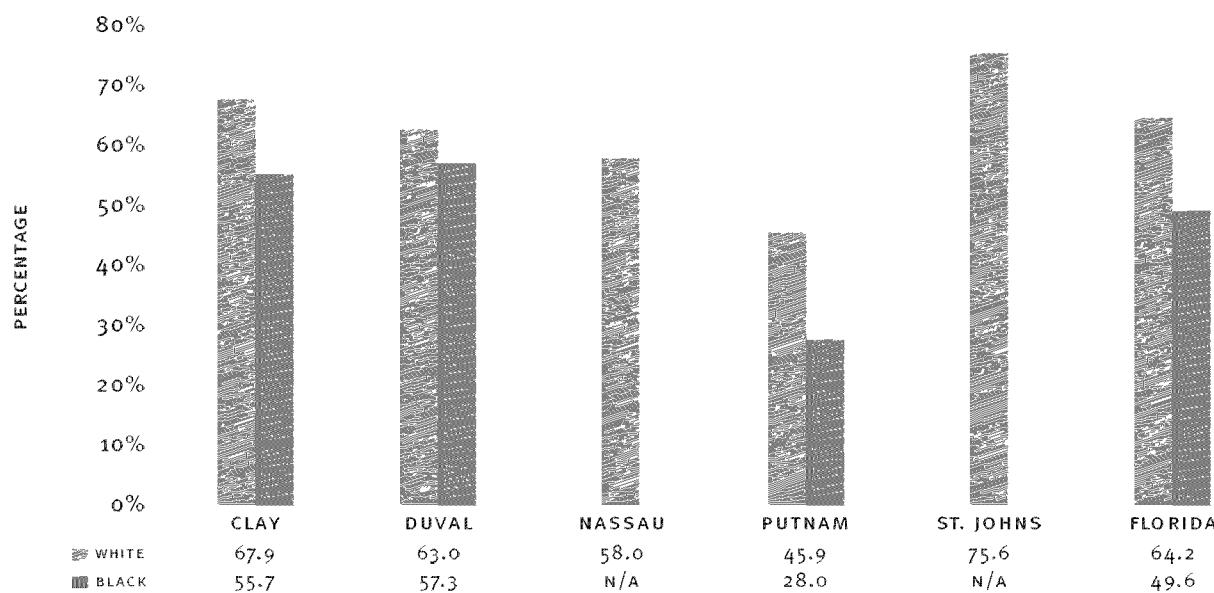
Source: 2010 Florida Behavioral Risk Factor Surveillance System (BRFSS) Data Report

CHART 7-4 ADULTS WHO HAD A PERMANENT TOOTH REMOVED BECAUSE OF TOOTH DECAY OR GUM DISEASE



Source: 2010 Florida Behavioral Risk Factor Surveillance System (BRFSS) Data Report

CHART 7-5 PERCENTAGE OF ADULTS WHO HAD THEIR TEETH CLEANED IN THE PAST YEAR



Source: 2010 Florida Behavioral Risk Factor Surveillance System (BRFSS) Data Report

TABLE 7-1 DISEASES OF HARD TISSUES OF TEETH – ADULTS 18+

	CLAY	DUVAL	NASSAU	PUTNAM	ST. JOHNS
2008	301	2,129	152	434	650
2009	394	2,620	164	162	537
2010	303	2,166	183	374	400

Source: AHCA Emergency Department Database Files CY 2008, 2009 & 2010

TABLE 7-2 DISEASES OF HARD TISSUES OF TEETH – PEDIATRIC (17 AND YOUNGER)

	CLAY	DUVAL	NASSAU	PUTNAM	ST. JOHNS
2008	27	142	6	19	23
2009	26	146	11	5	14
2010	19	122	2	16	20

Source: AHCA Emergency Department Database Files CY 2008, 2009 & 2010

TABLE 7-3 DISEASES OF PULP AND PERIAPICAL TISSUES – ADULTS 18+

	CLAY	DUVAL	NASSAU	PUTNAM	ST. JOHNS
2008	173	1,676	207	194	243
2009	192	1,733	164	180	174
2010	266	1,891	98	122	169

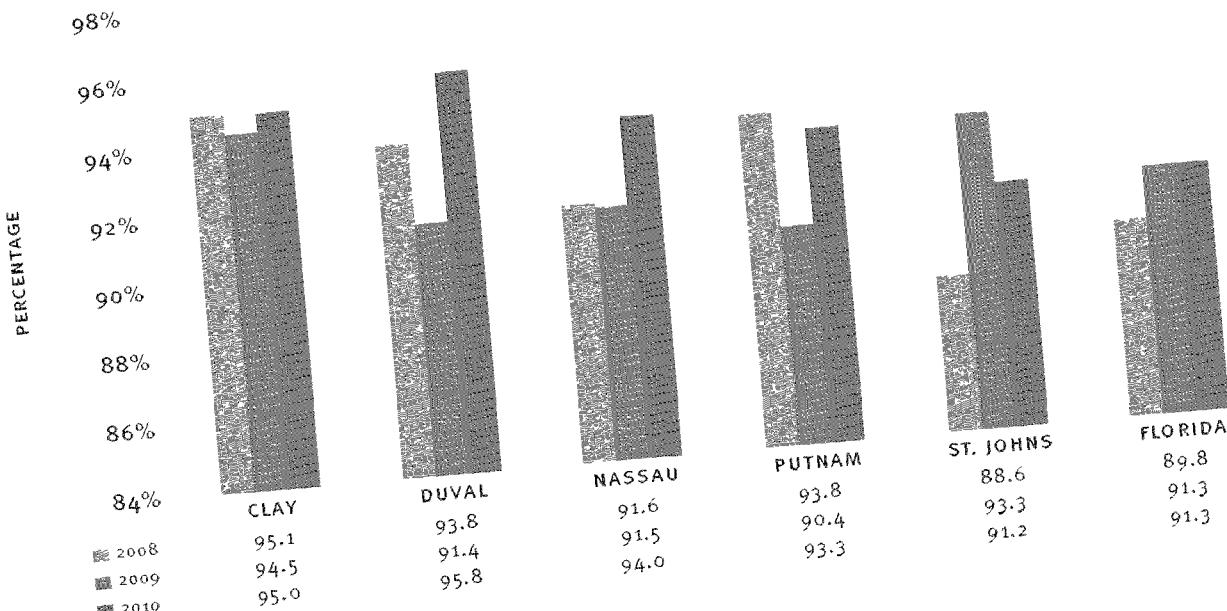
Source: AHCA Emergency Department Database Files CY 2008, 2009 & 2010

TABLE 7-4 DISEASES OF PULP AND PERIAPICAL TISSUES - PEDIATRIC (17 AND YOUNGER)

	CLAY	DUVAL	NASSAU	PUTNAM	ST. JOHNS
2008	21	155	8	13	11
2009	16	164	9	7	16
2010	10	168	8	4	10

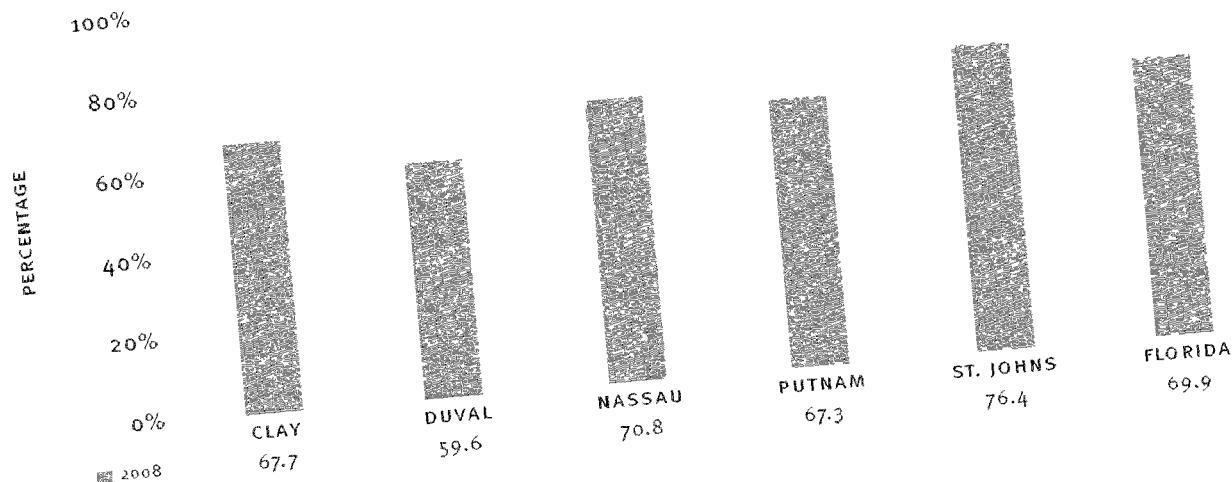
Source: AHCA Emergency Department Database Files for 2008, 2009 & 2010

CHART 7-6 IMMUNIZATION LEVELS IN KINDERGARTEN



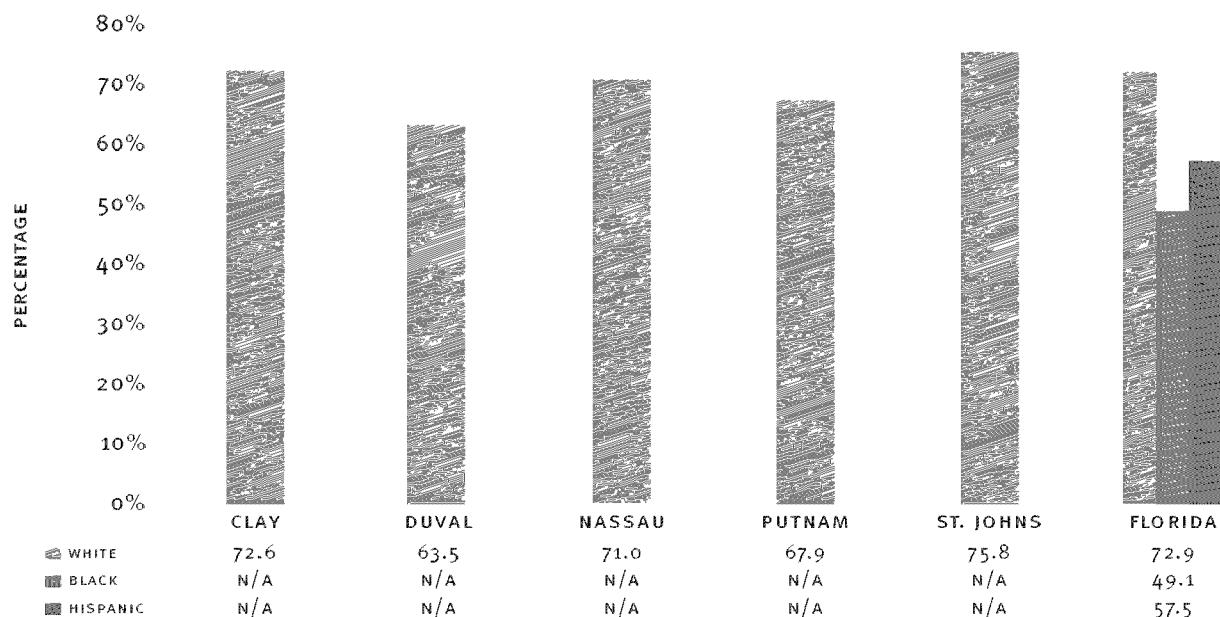
Source: Florida Department of Health, Bureau of Immunization

CHART 7-7 ADULTS AGES 65+ WHO HAVE EVER RECEIVED A PNEUMONIA VACCINATION



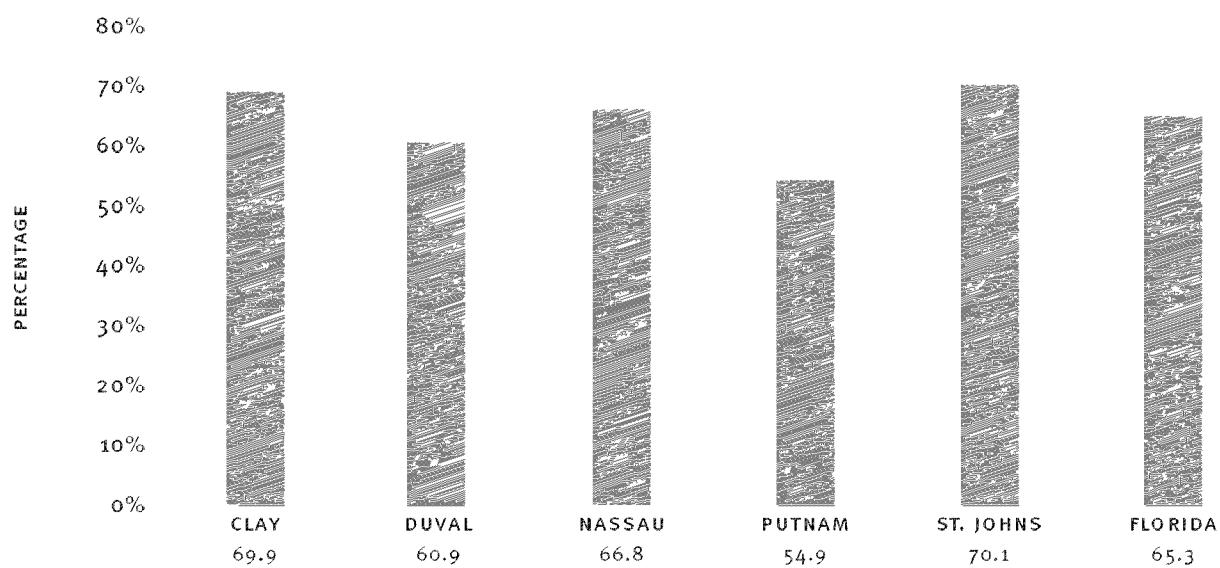
Source: Florida Behavioral Risk Factor Surveillance System (CHARTS)

CHART 7-8 ADULTS AGES 65+ WHO HAVE EVER RECEIVED A PNEUMONIA VACCINATION, BY RACE



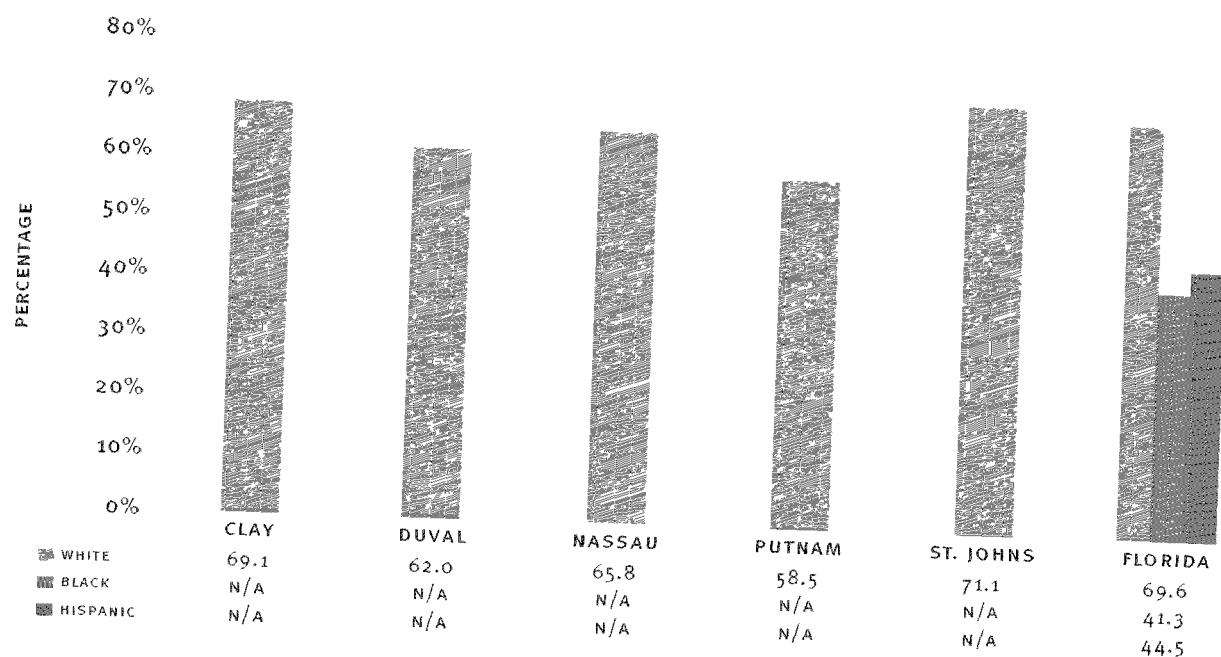
Source: Florida Behavioral Risk Factor Surveillance System (CHARTS)

CHART 7-9 ADULTS AGES 65+ WHO RECEIVED A FLU SHOT IN THE PAST YEAR



Source: Florida Behavioral Risk Factor Surveillance System (CHARTS)

CHART 7-10 ADULTS AGES 65+ WHO RECEIVED A FLU SHOT IN THE PAST YEAR, BY RACE



Source: Florida Behavioral Risk Factor Surveillance System (CHARTS)



CHAPTER 8: HEALTH CONDITIONS AND DISEASES

CHRONIC DISEASES

Cancer

Overall, cancer rates have fallen since 2008 in all counties except for Putnam. Clay, Duval and Putnam Counties' rates in 2010 were above the state rate of 159.2. See Chart 8-1 for comparisons of cancer rates for each county. Survey data indicate that respondents are not very concerned about cancer. In focus groups, respondents with cancer notice

Cancer rates across races vary by county. In Clay County, the rate for White residents is far higher than that of Black residents. In Duval County, Black and White individuals have similar rates of cancer, and the Hispanic rate is less than half of that. Nassau and St. Johns Counties see higher rates in the Black population. The rates across race are much more even at the state level. See Chart 8-2 for cancer rates by race

Charts 8-3 through 8-5 detail trends in rates for lung, colorectal and breast cancers. 2010 rates for lung cancer are higher than the state level in all counties except St. Johns. Additionally, rates in all counties have decreased since 2008. The data for colorectal cancer paint a different story. The rate is highest in Putnam County and had increased in Duval County since 2008. Breast cancer rates have increased drastically in Putnam and St. Johns Counties. Only Nassau County has a rate below the state level of 21 per 100,000.

Heart Disease and Stroke

Hypertension rates are outlined by race and gender in Charts 8-6 and 8-7. Duval County has the highest rate for Black residents, while Putnam County has the highest affected White population. Nassau and St. Johns Counties did not have data to report for their Black populations. Additionally, in all counties and throughout the state of Florida, men have higher rates than women.

Putnam County is the only one in the region to see an increase in the rate of coronary heart disease from 2008-2010. See Chart 8-8 for trend data for each county. Overall, rates of coronary heart disease are higher for Black individuals than for White and Hispanic residents. Minority data was not available for St. Johns County and Hispanic data was missing for Nassau and Putnam Counties. See Chart 8-9 for rates by race

In most counties, the 2010 rate for stroke is higher than the state level of 29.8 per 100,000. However, most counties have seen a decrease since 2008. See Chart 8-10 for a comparison of stroke rates across counties from 2008 through 2010. As Charts 8-11 and 8-12 show, Black residents have higher levels of stroke than their White and Hispanic counterparts. Note the lack of data for minorities in most counties. The distribution of strokes across gender varies by county. In Duval and Clay Counties, female percentages are higher than male.

Respiratory Diseases

Rates of chronic lower respiratory disease have declined in all counties, but most still lie above the state level. Comparisons of asthma rates across race are difficult due to the residents in some counties and in any of the counties. For middle and high school students, the trends vary by county. Some counties have seen an increase and others have improved. Additionally, some counties lie above the state average and others are lower. See Charts 8-16 and 8-17 for data on asthma in middle and high school students. Chart 8-18 illustrates that asthma hospitalizations have increased since 2008 in every county and throughout the state. Charts 8-19 and 8-20 detail hospitalizations for children of varying ages.

Diabetes

Diabetes death rates are higher than the state level (19.3 per 100,000) in Clay, Duval and Putnam Counties (see Chart 8-21). When this indicator is broken down by race, the rates for

See Chart 8-22 for more details.) Note the Chart 8-23 outlines a slight increase in all counties in the rate of hospitalizations from or with diabetes. Diabetes

8-24 to see how these rates compare to the state level

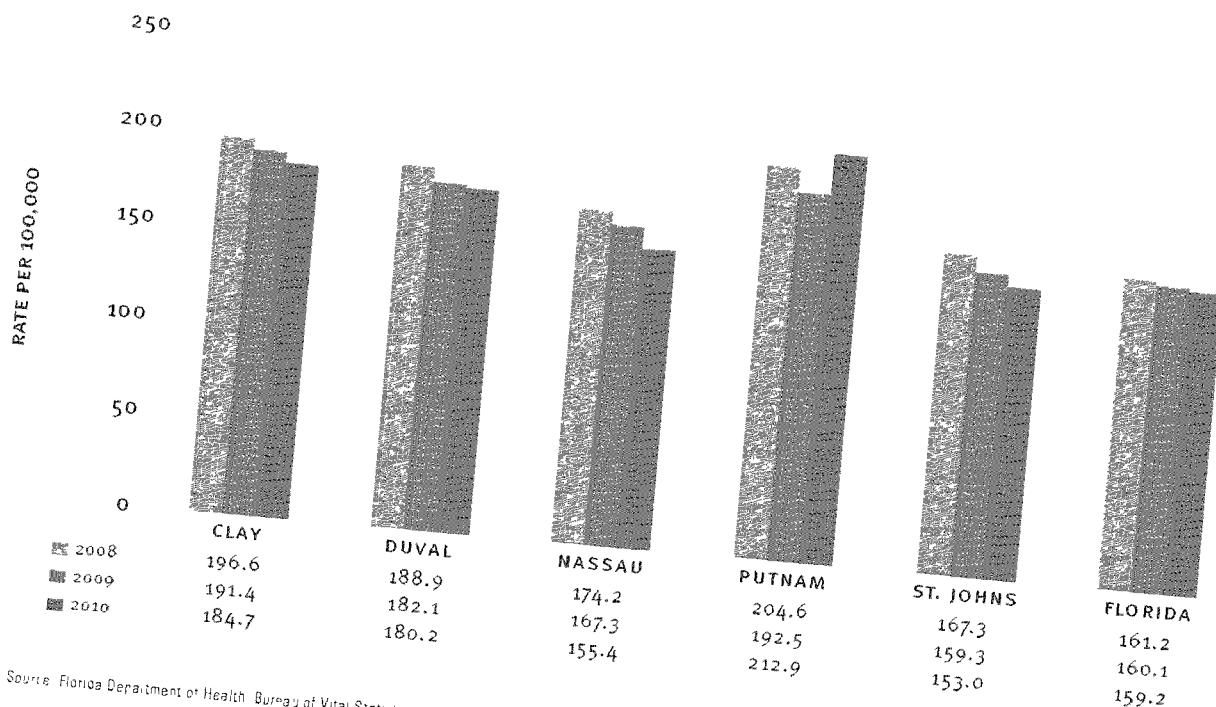
In all counties See Chart

Putnam County has the highest percentage of adults with diagnosed diabetes. Those adults ages 65 and older have the highest percentage. Racially, Black residents generally have higher rates. Charts 8-25 to 8-27 detail these indicators. Chart 8-28 shows that males have higher rates than women in all counties and throughout the state. Hospitalizations from amputation of a lower extremity attributable to diabetes have increased in all counties.

Key Findings

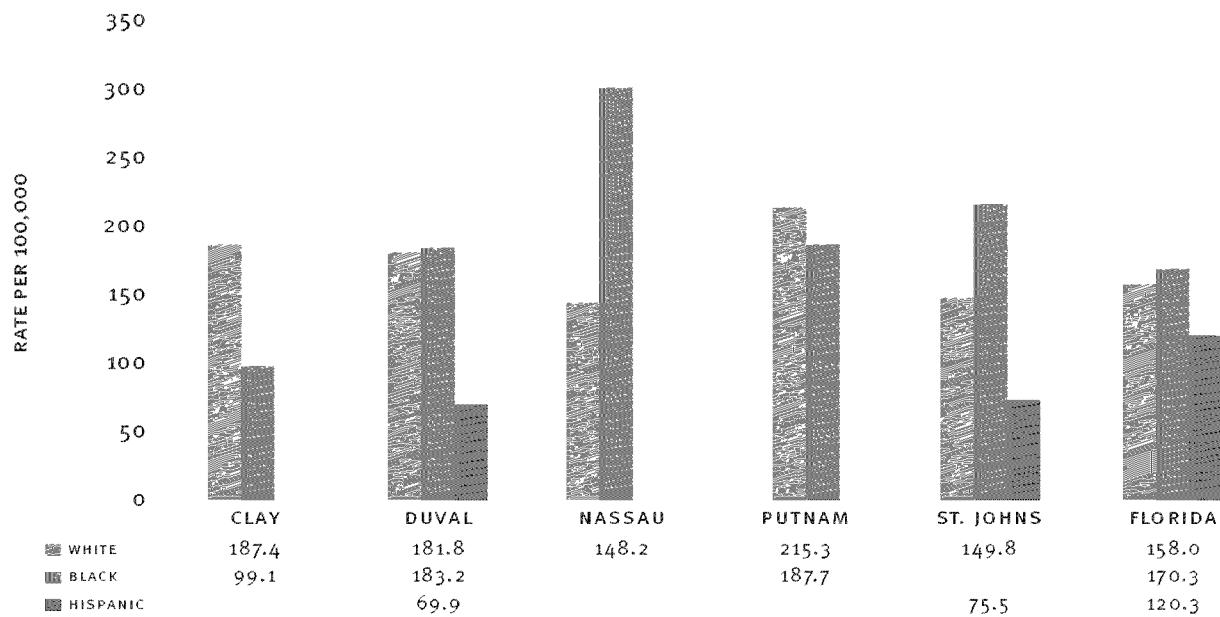
- Cancer rates have fallen since 2008 in all counties except for Putnam. Survey data indicate that respondents are not very concerned about cancer.
- Cancer rates across races vary by county.
- Putnam County is the only county in the region to see an increase in the rate of coronary heart disease from 2008 to 2010.
- Rates of coronary heart disease are higher for Black individuals than for White and Hispanic residents level.
- Rates of chronic lower respiratory disease have declined in all counties, but most still lie above the state level.
- Diabetes death rates are higher than the state level in Clay, Duval and Putnam Counties. The rates for Black residents are far higher than those of White residents.
- Putnam County experienced the highest rates of hospitalizations from amputation of lower extremities and was significantly higher compared to the state averages.

CHART 8-1 CANCER



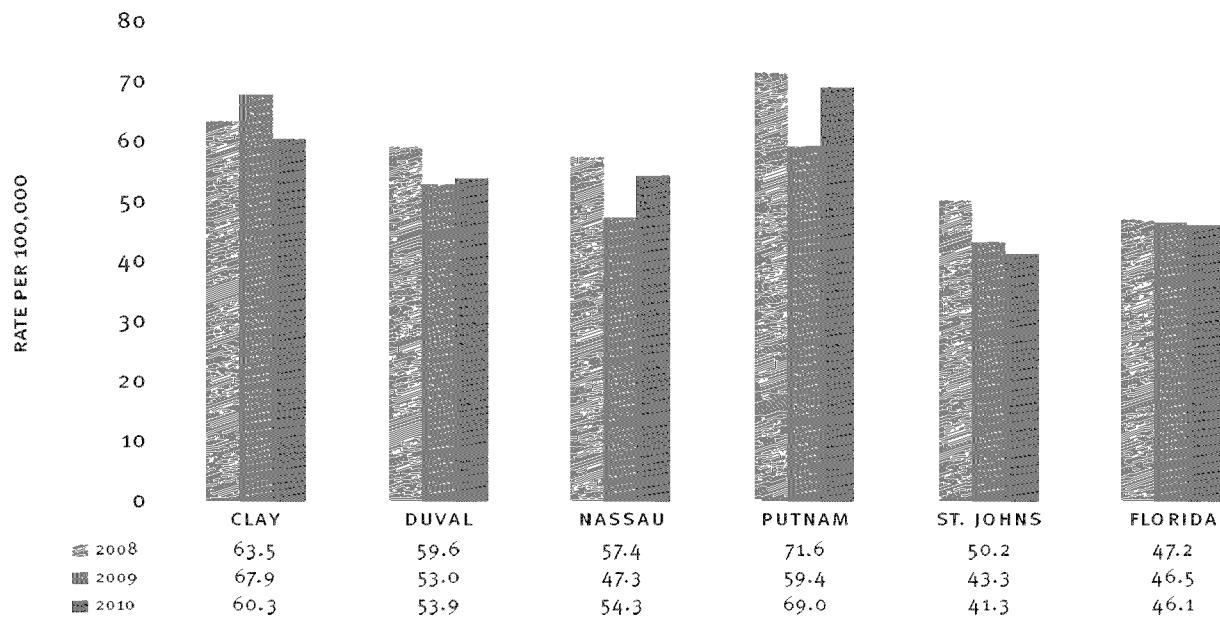
Source: Florida Department of Health, Bureau of Vital Statistics

CHART 8-2 CANCER, BY RACE



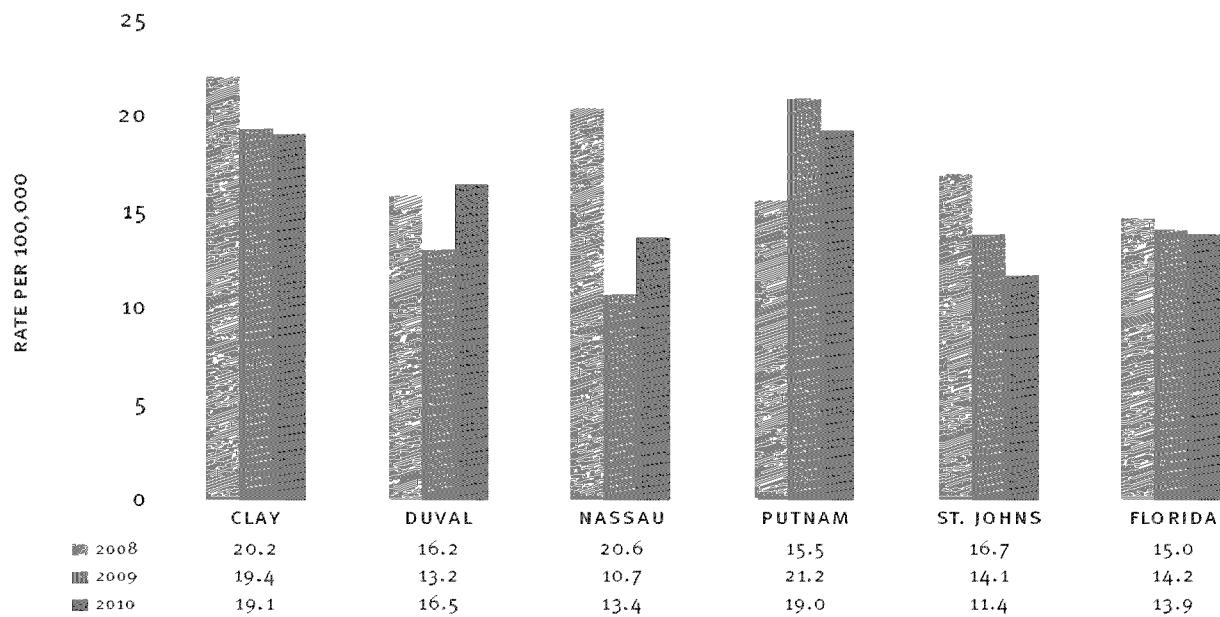
Source: Florida Department of Health Bureau of Vital Statistics

CHART 8-3 LUNG CANCER



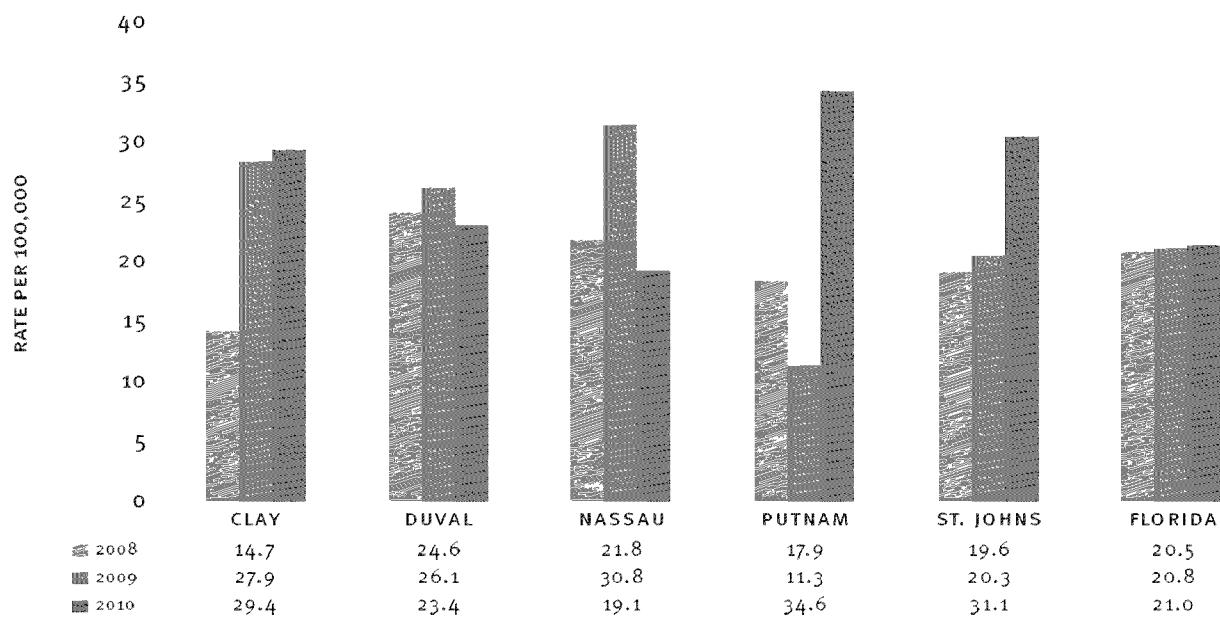
Source: Florida Department of Health Bureau of Vital Statistics

CHART 8-4 COLORECTAL CANCER



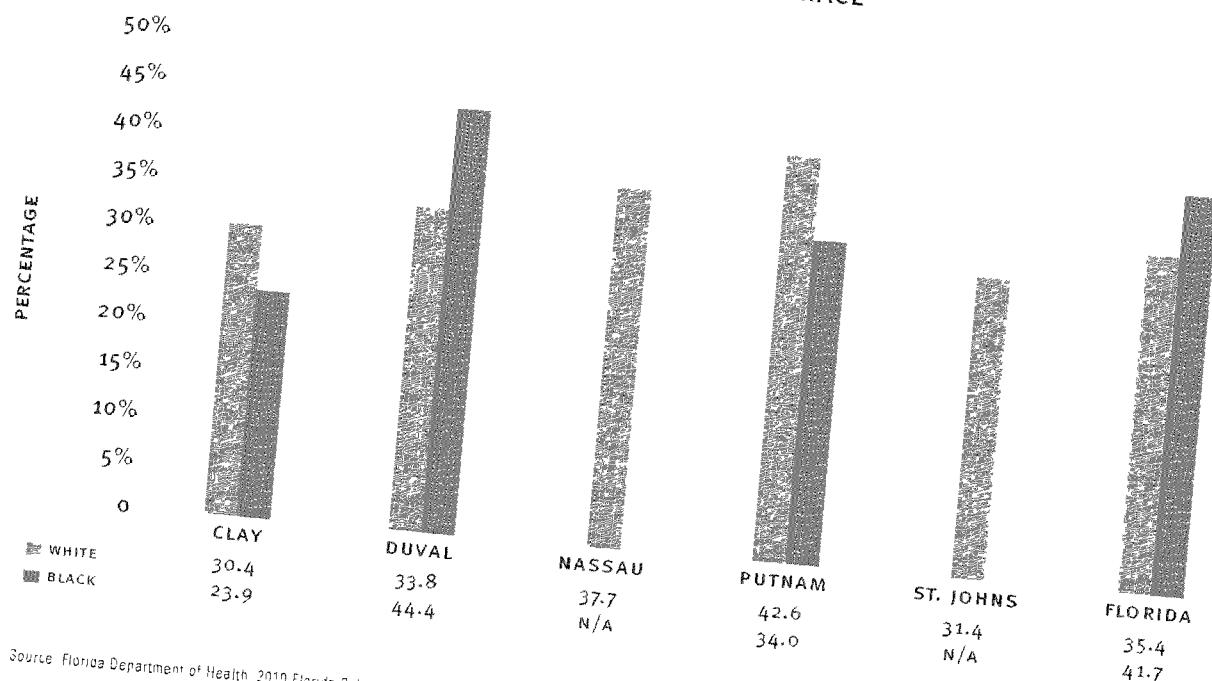
Source: Florida Department of Health Bureau of Vital Statistics

CHART 8-5 BREAST CANCER



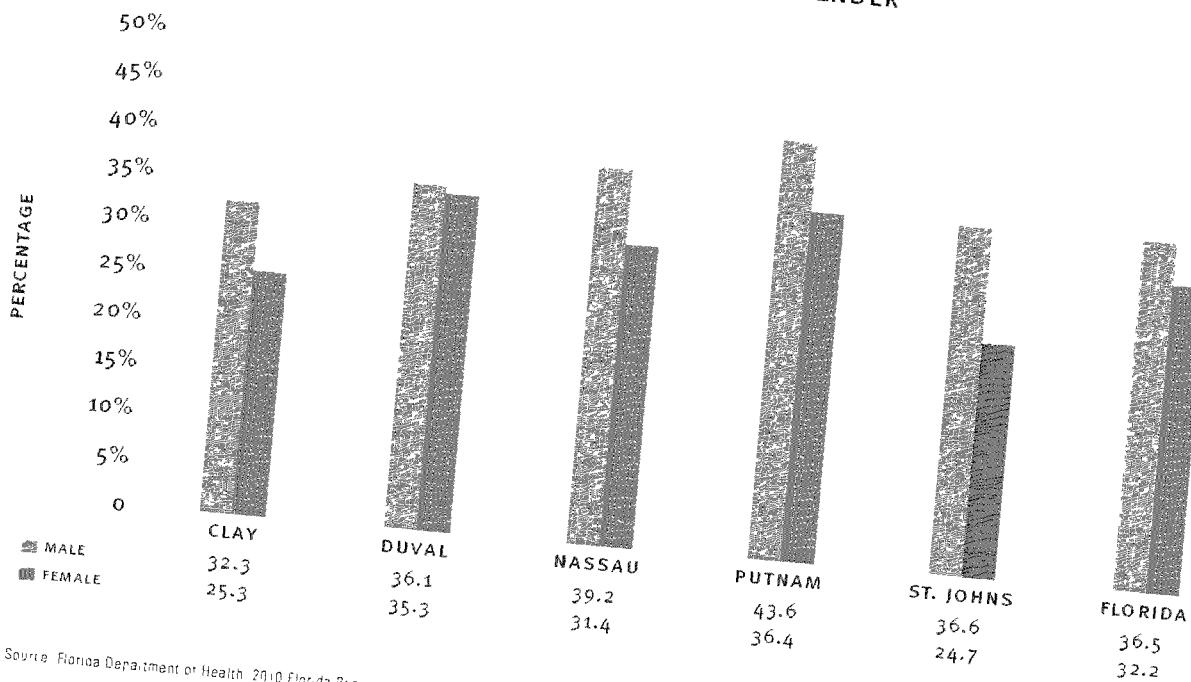
Source: Florida Department of Health Bureau of Vital Statistics

CHART 8-6 ADULTS WITH DIAGNOSED HYPERTENSION, BY RACE



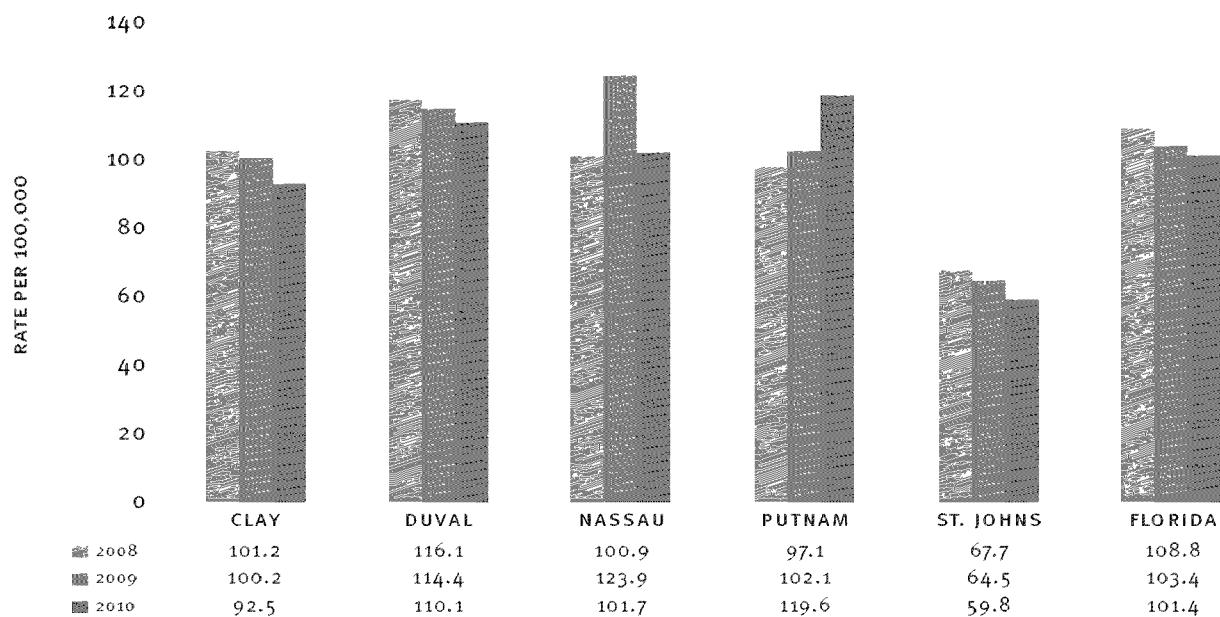
Source: Florida Department of Health 2010 Florida Behavioral Risk Factor Surveillance System (BRFSS) Data Report

CHART 8-7 ADULTS WITH DIAGNOSED HYPERTENSION, BY GENDER



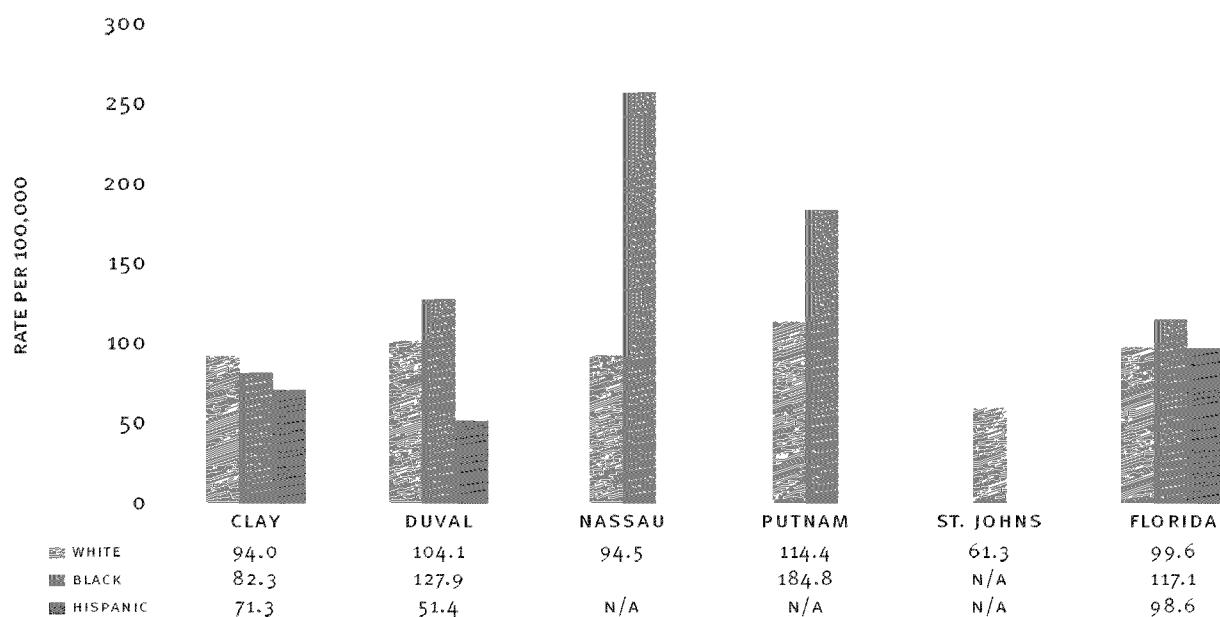
Source: Florida Department of Health 2010 Florida Behavioral Risk Factor Surveillance System (BRFSS) Data Report

CHART 8-8 CORONARY HEART DISEASE



Source: Florida Department of Health Bureau of Vital Statistics

CHART 8-9 CORONARY HEART DISEASE, BY RACE



Source: Florida Department of Health Bureau of Vital Statistics

CHART 8-10

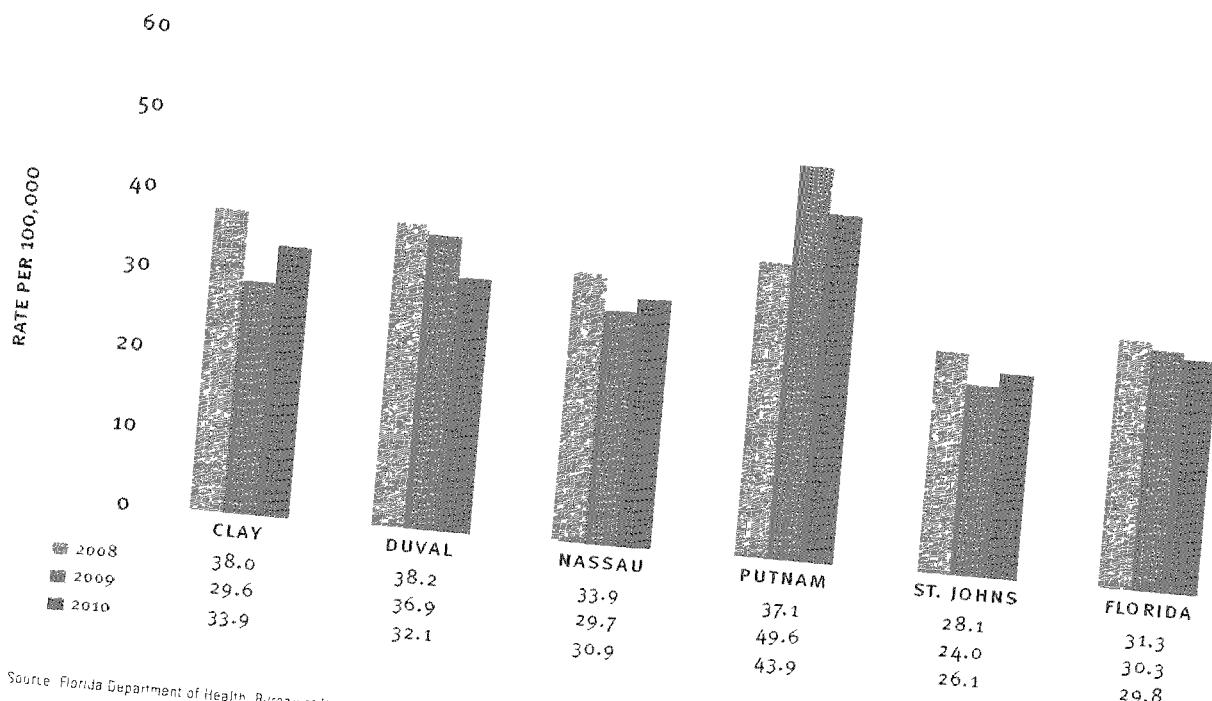


CHART 8-11 STROKE, BY RACE

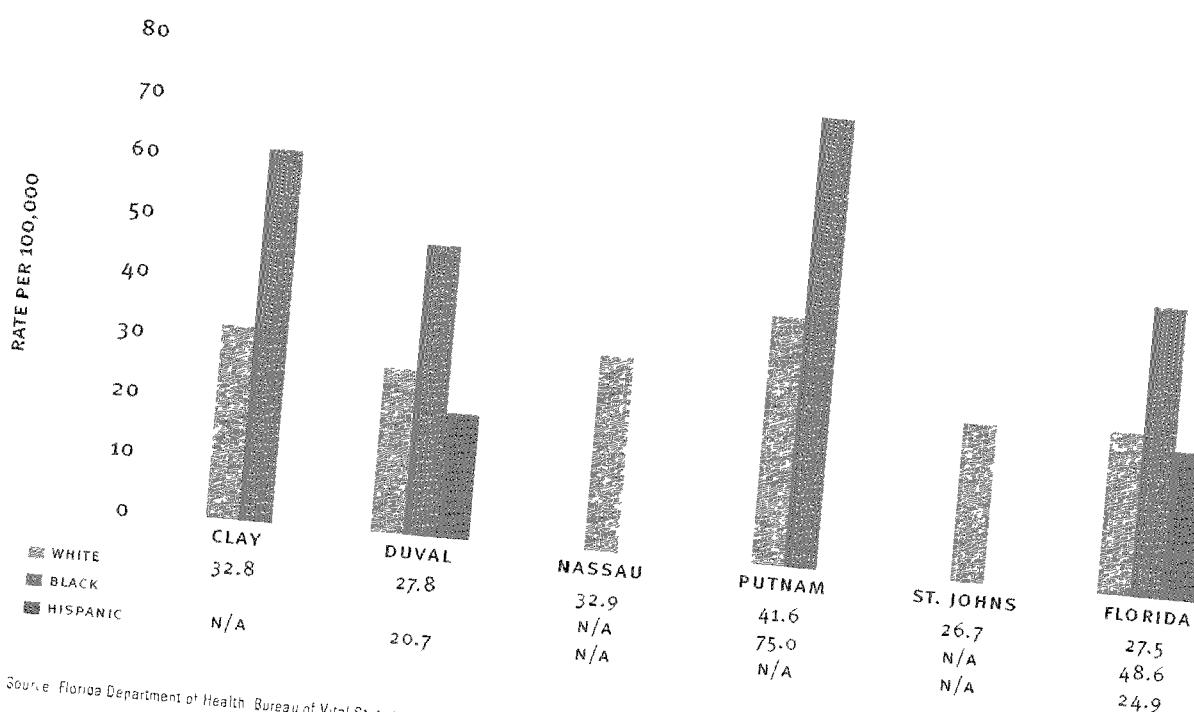


CHART 8-12 ADULTS WHO HAVE EVER HAD STROKE, BY RACE

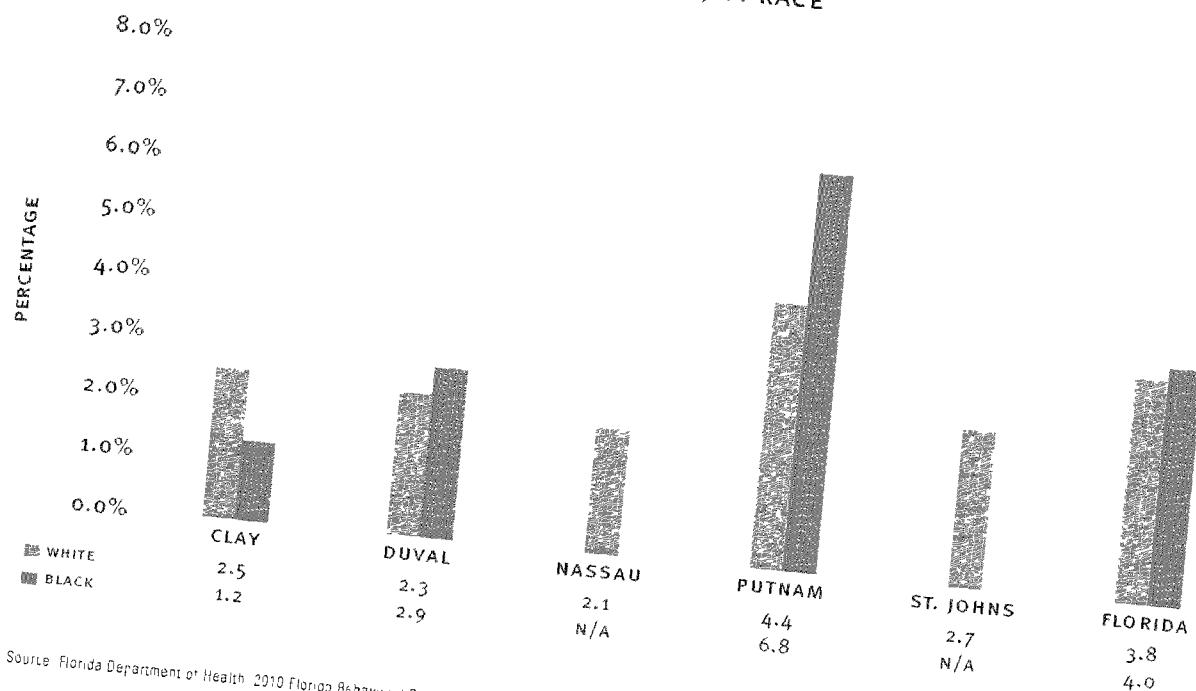


CHART 8-13

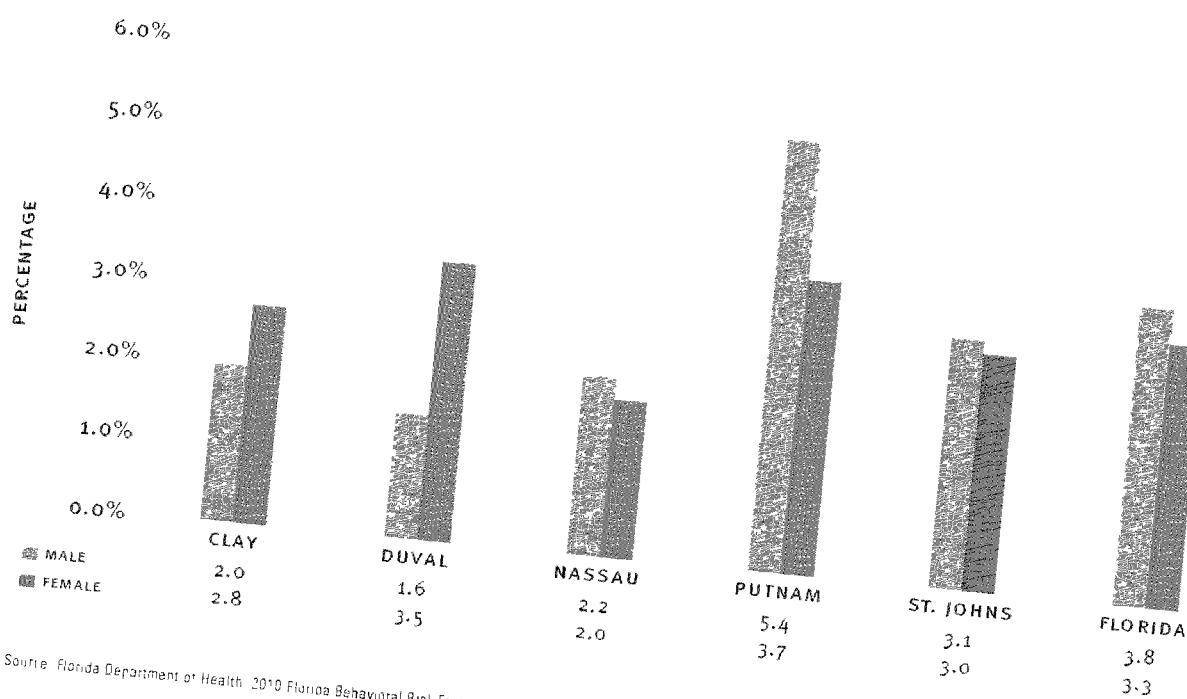


CHART 8-14

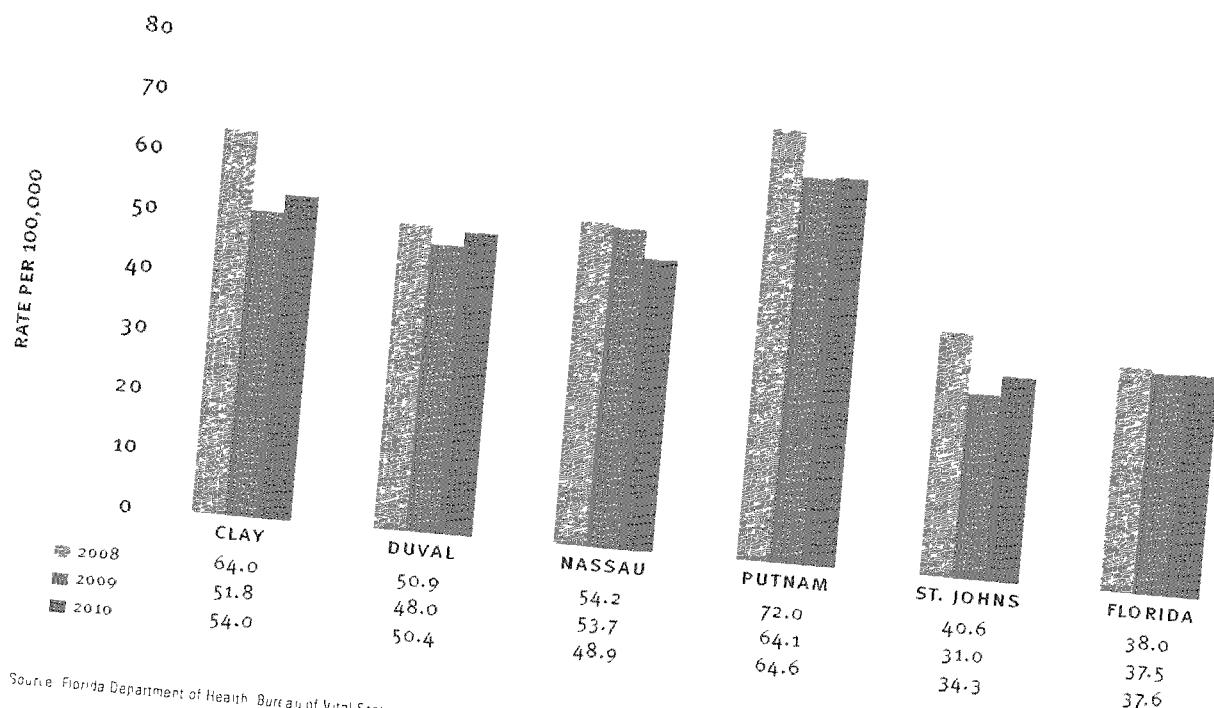


CHART 8-15 ADULTS WHO CURRENTLY HAVE ASTHMA, BY RACE

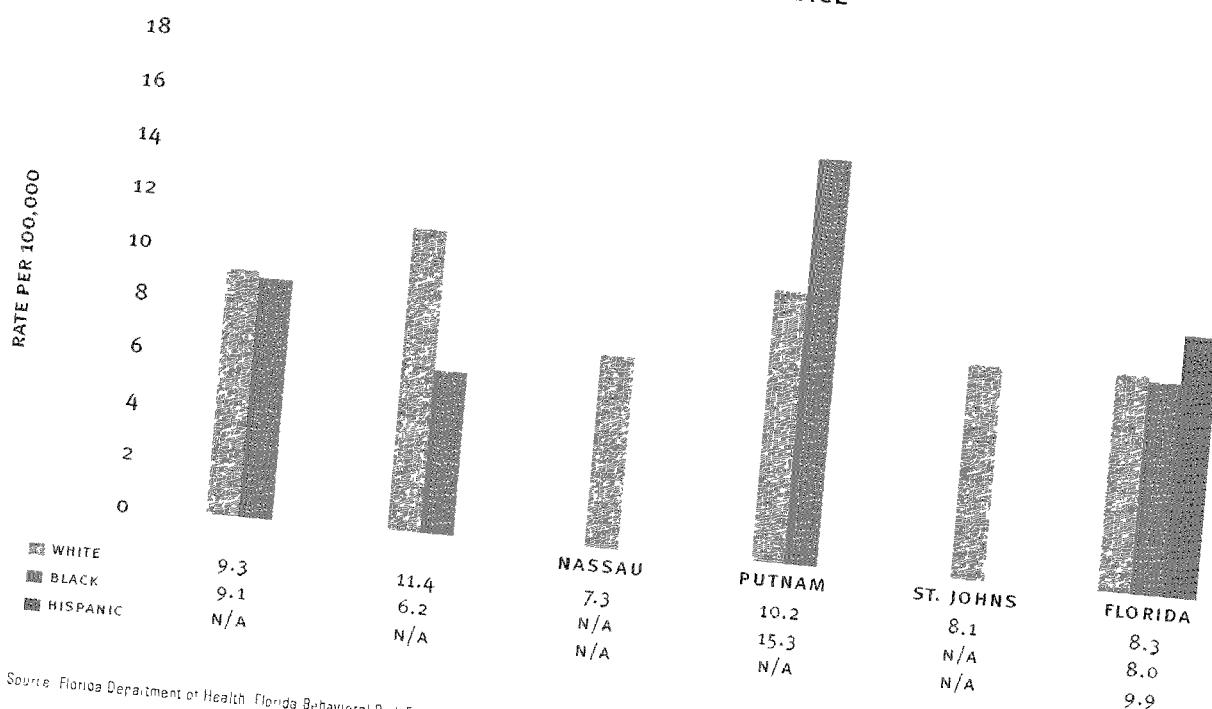
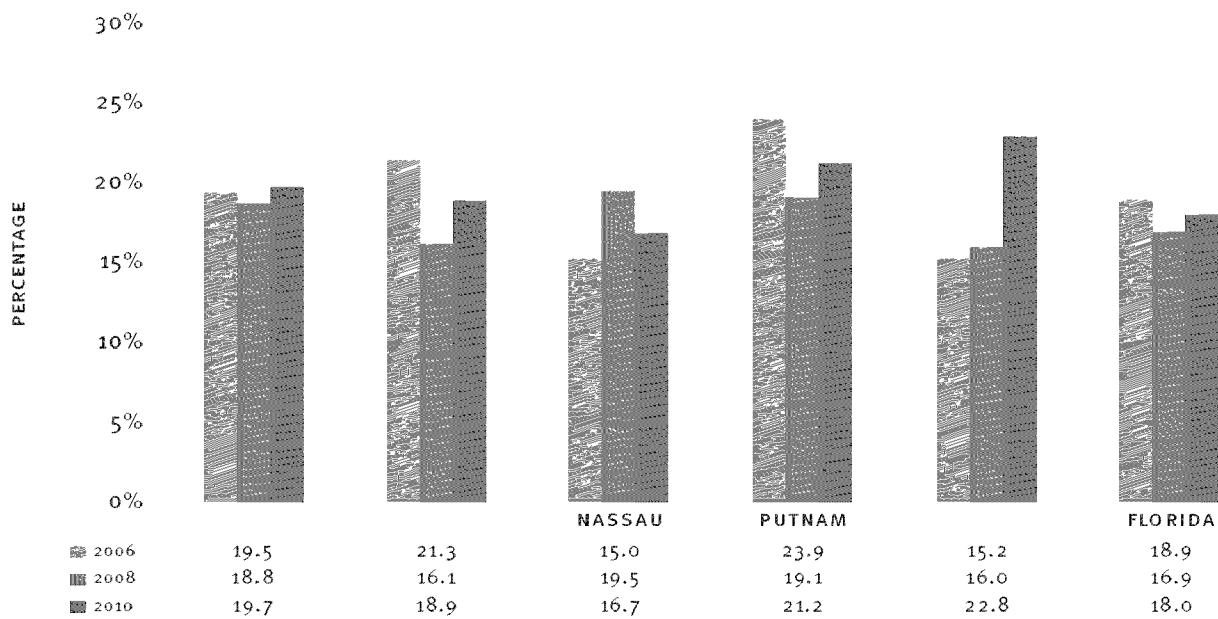
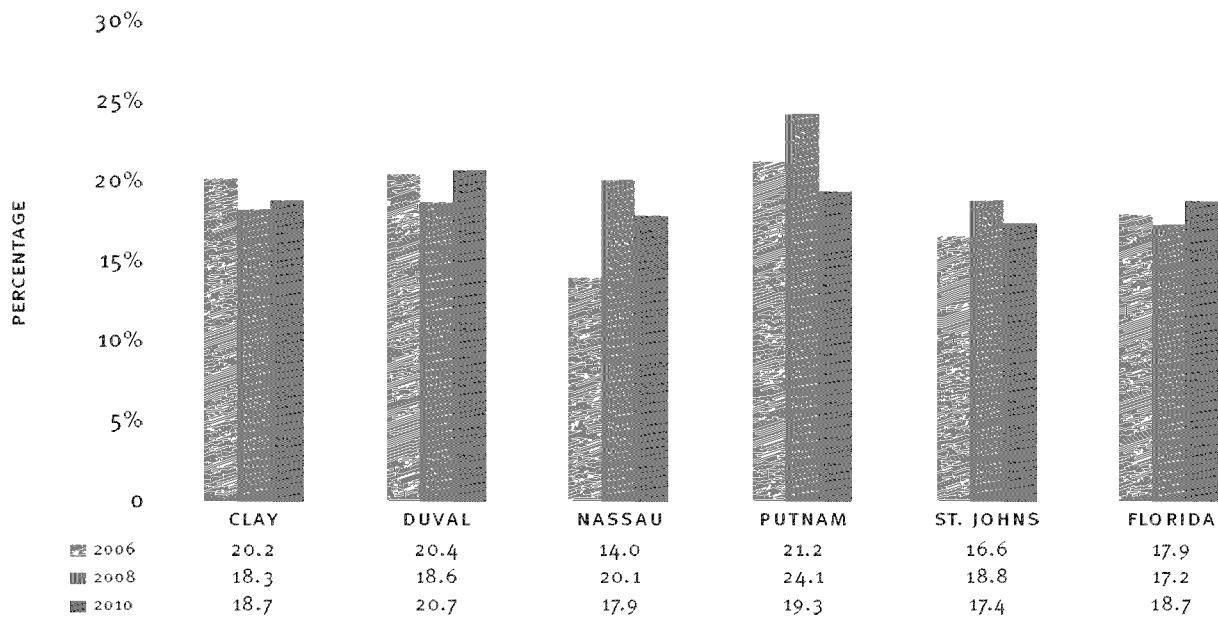


CHART 8-16 MIDDLE SCHOOL STUDENTS WITH ASTHMA



Source: Florida Department of Health Florida Youth Tobacco Survey

CHART 8-17 STUDENTS WITH ASTHMA



Source: Florida Department of Health Florida Youth Tobacco Survey

CHART 8-18

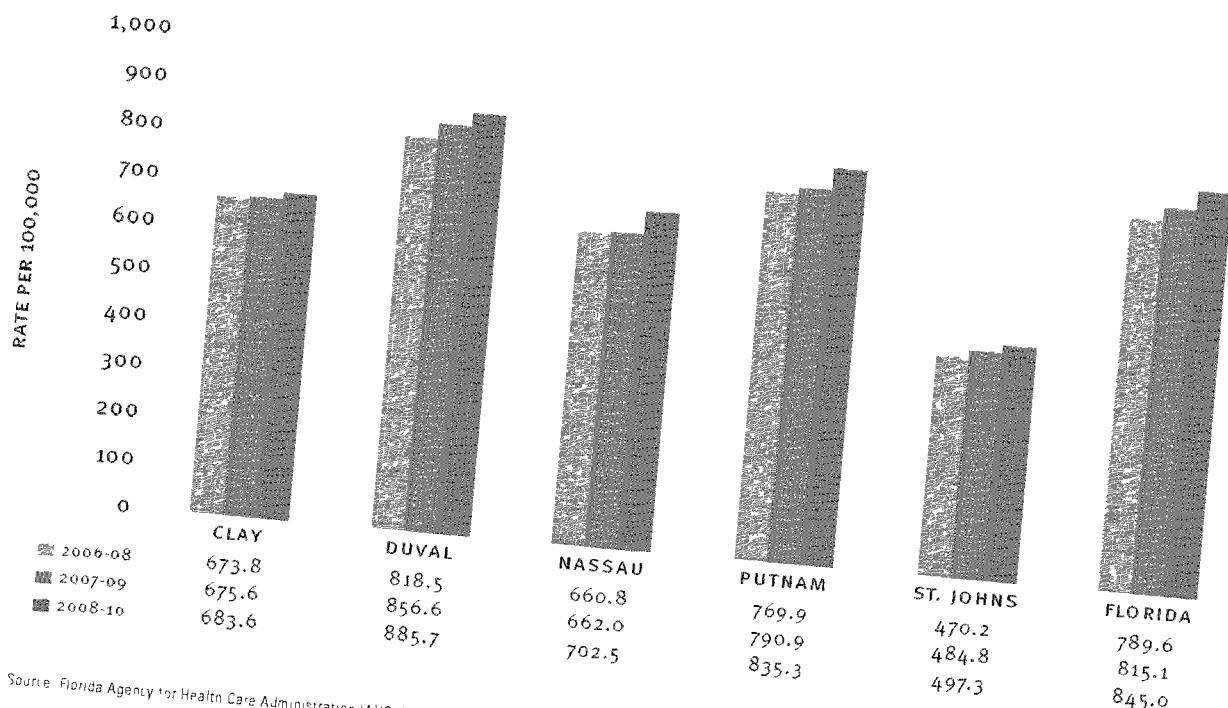


CHART 8-19 ASTHMA HOSPITALIZATIONS - AGES 1 THROUGH 5

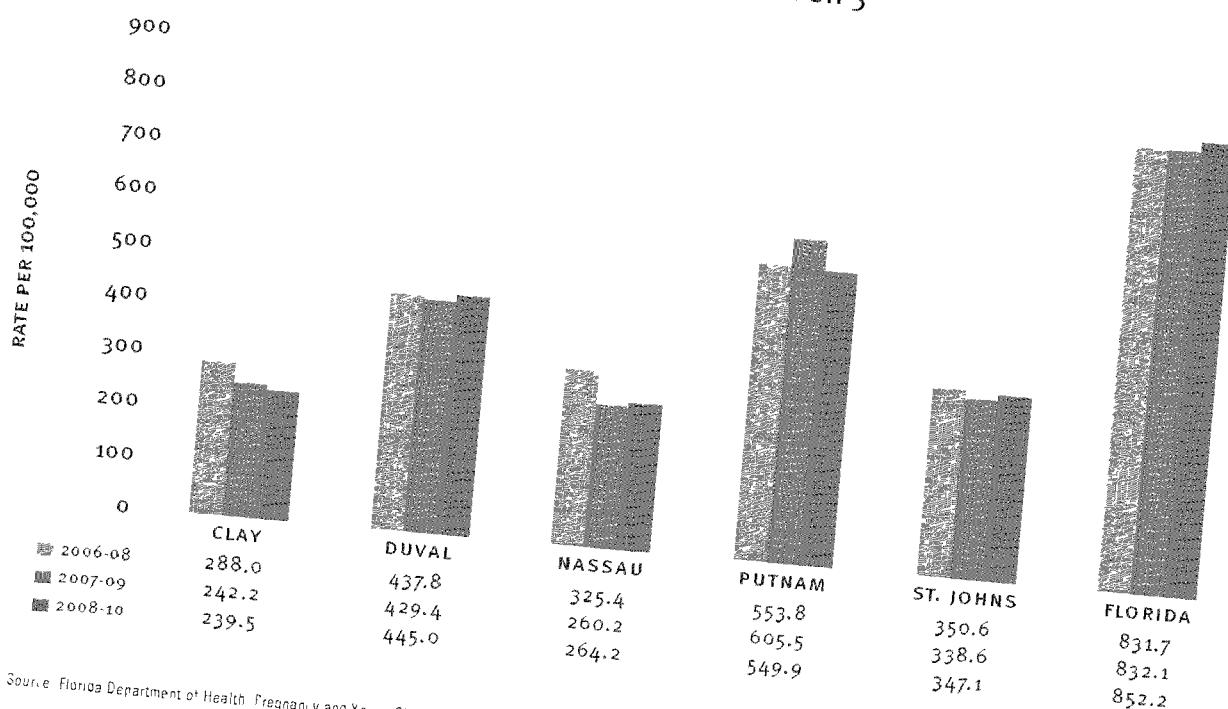


CHART 8-20 ASTHMA HOSPITALIZATIONS - CHILDREN

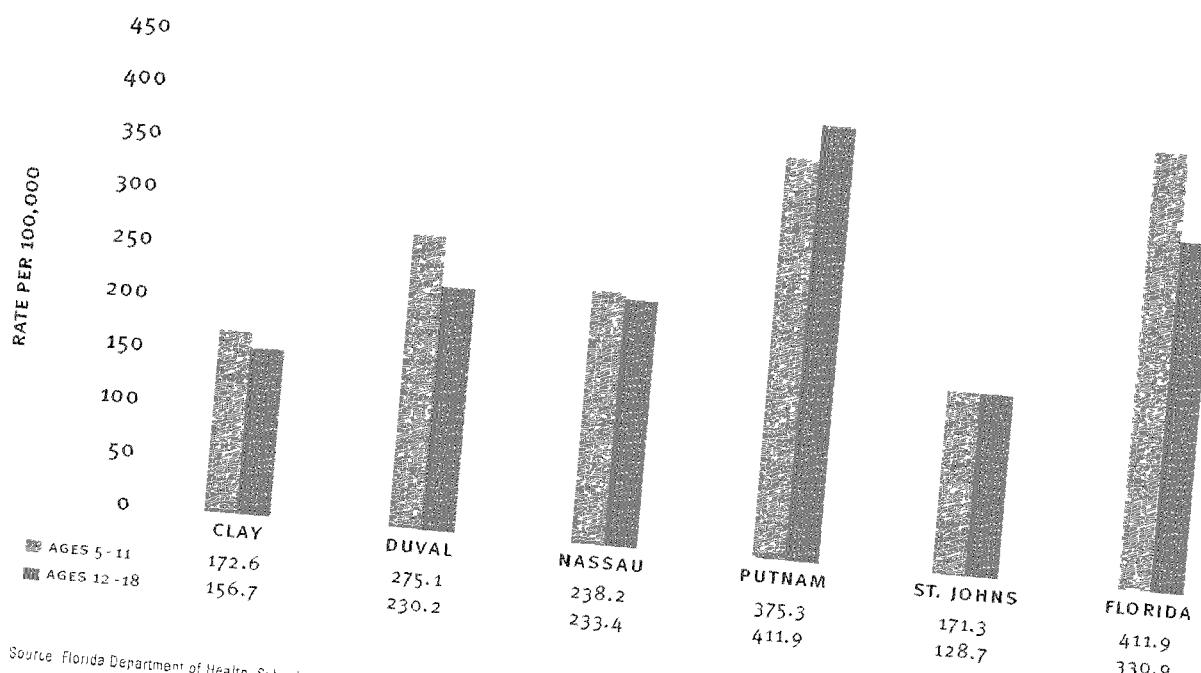


CHART 8-21 DIABETES - DEATH RATES

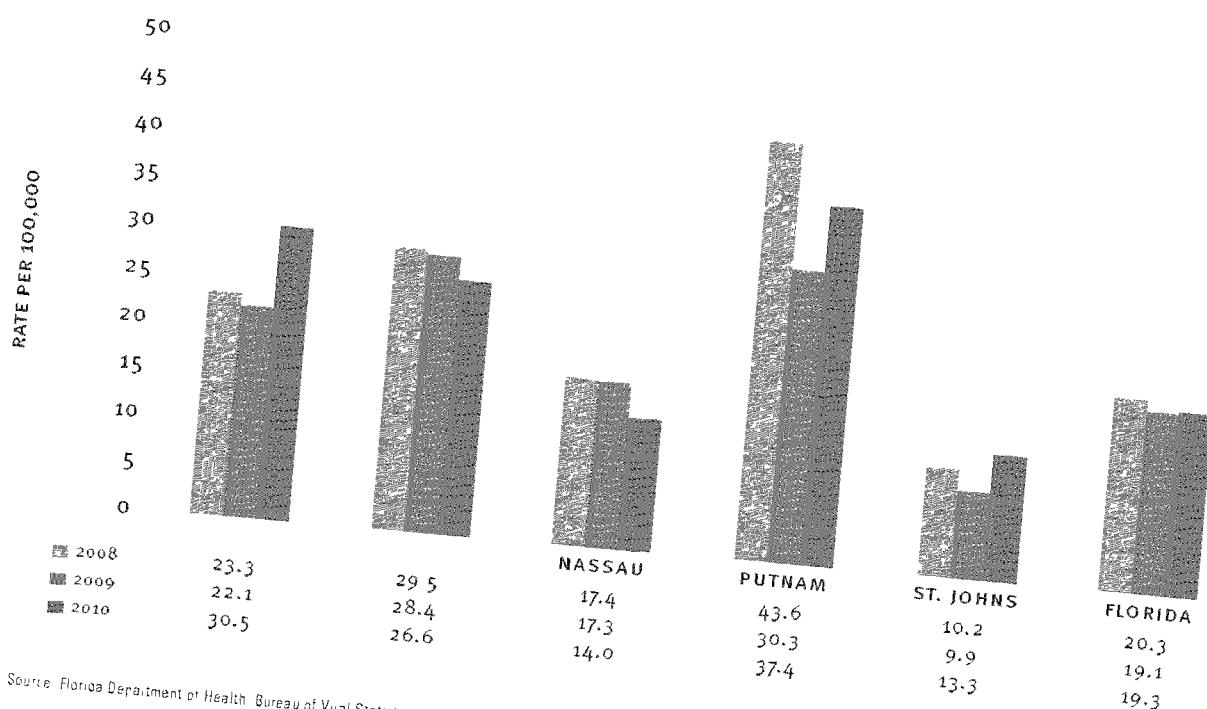


CHART 8-22 DIABETES - DEATH RATES,

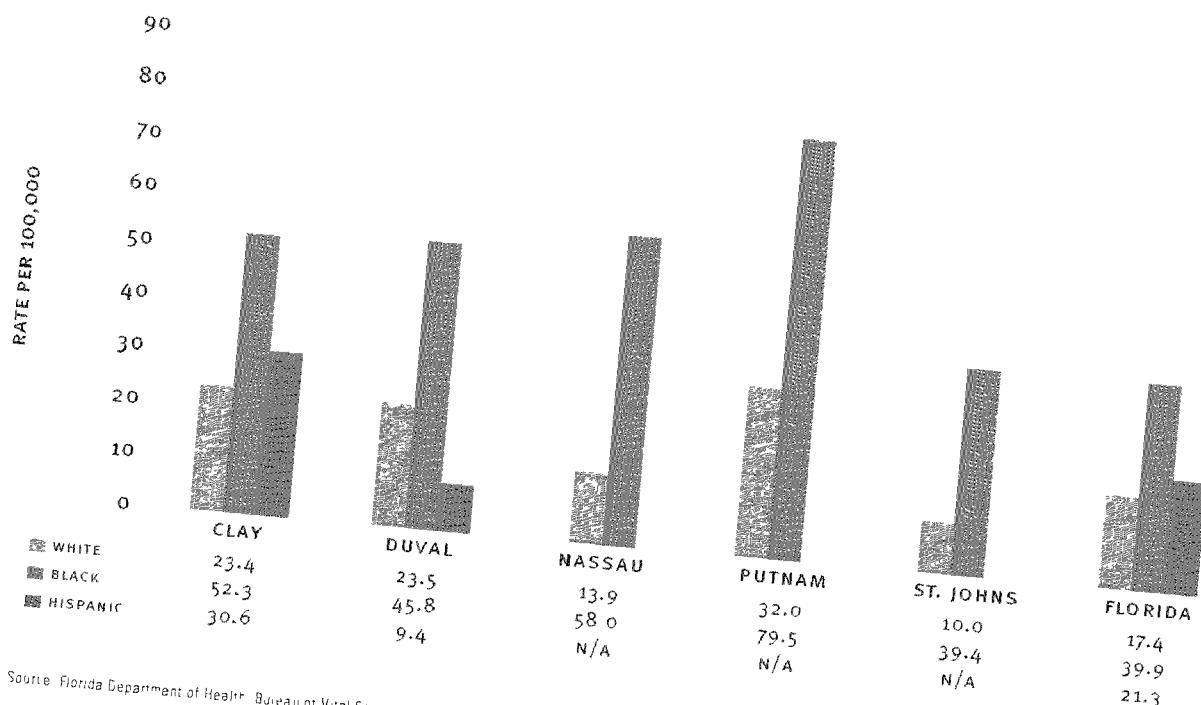


CHART 8-23 HOSPITALIZATIONS FROM OR WITH

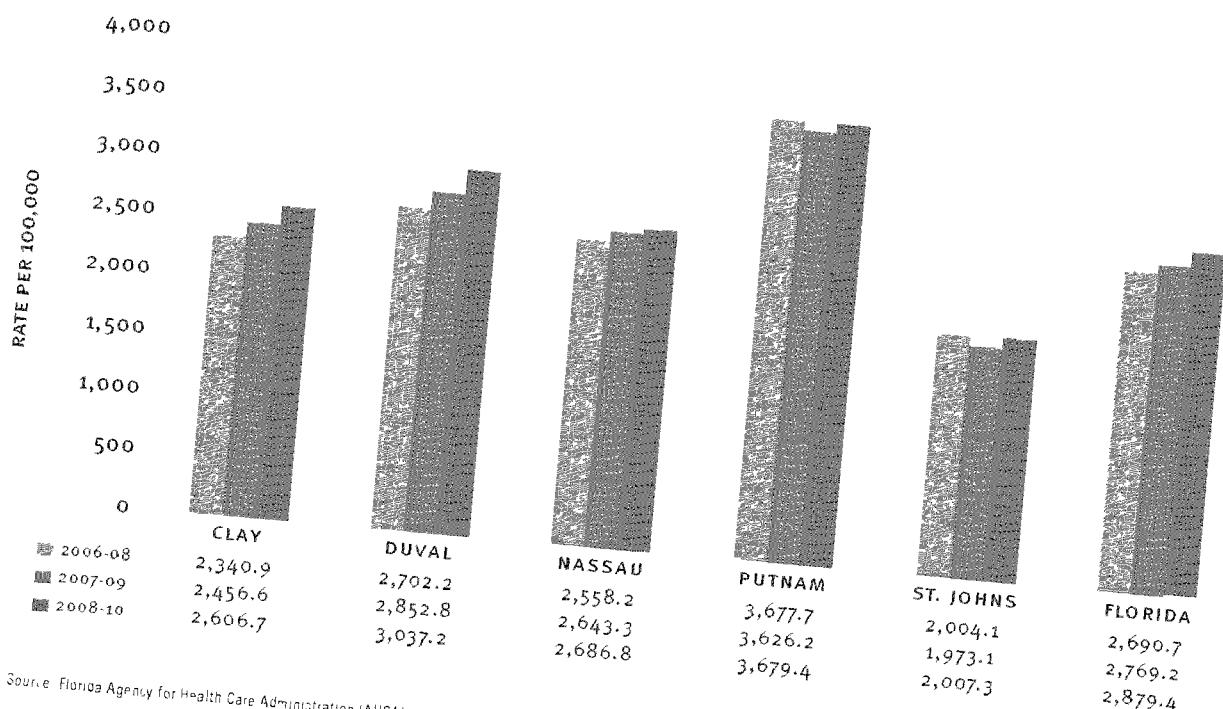
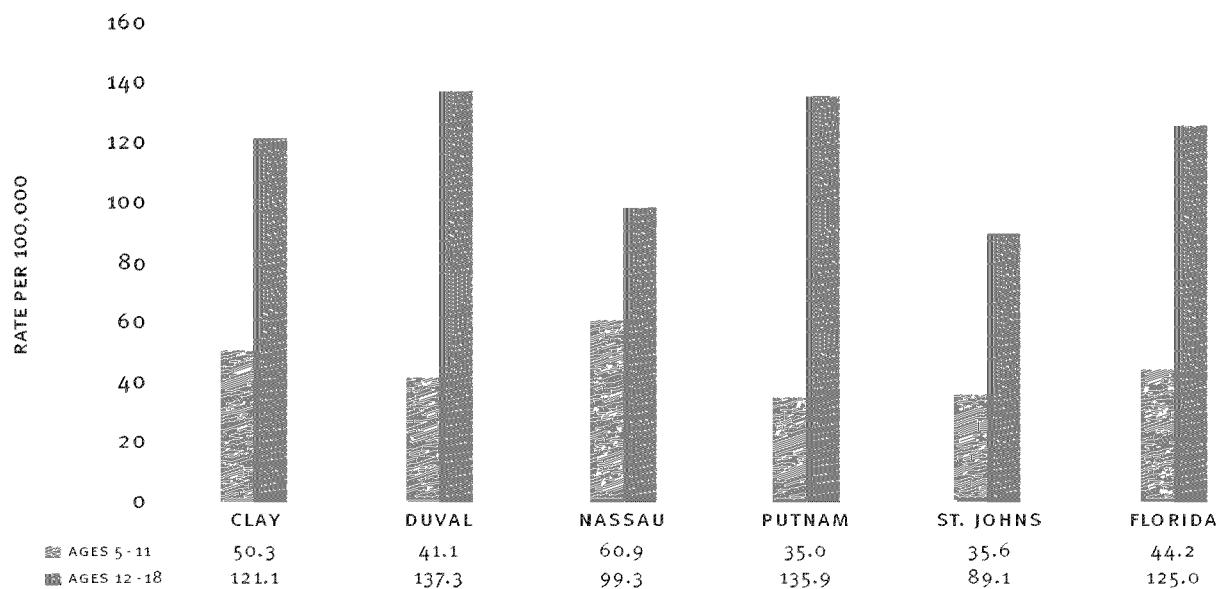
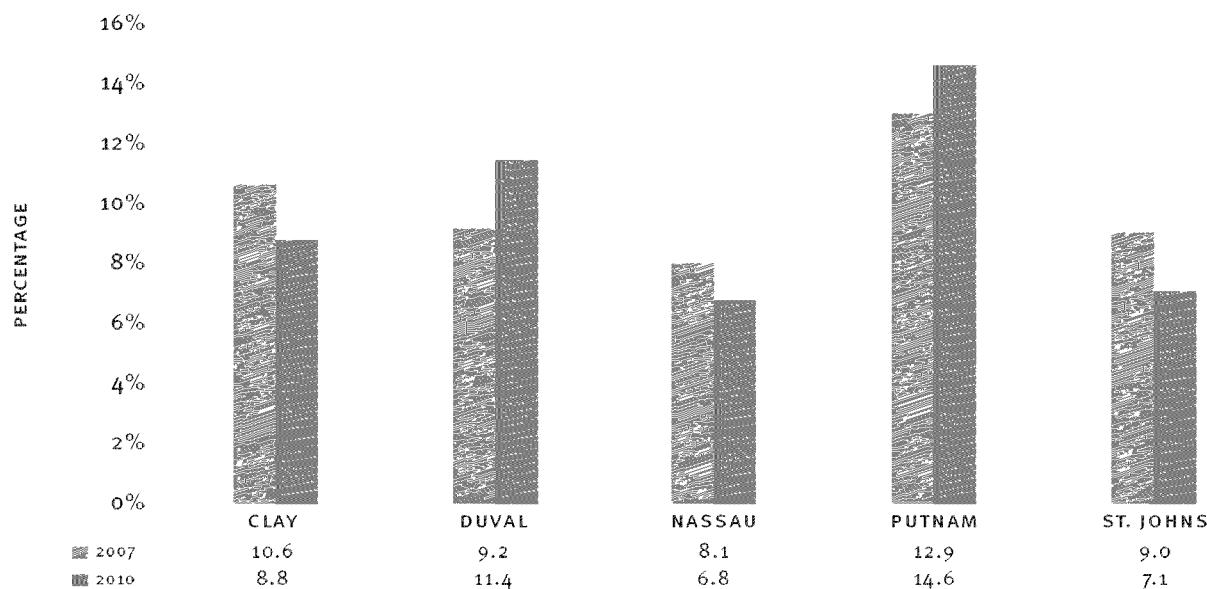


CHART 8-24 DIABETES HOSPITALIZATIONS – CHILDREN



Source: Florida Department of Health School-aged Child and Adolescent Profile

CHART 8-25 ADULTS WITH DIAGNOSED



Source: Florida Behavioral Risk Factor Surveillance System

CHART 8-26 ADULTS WITH DIAGNOSED DIABETES,

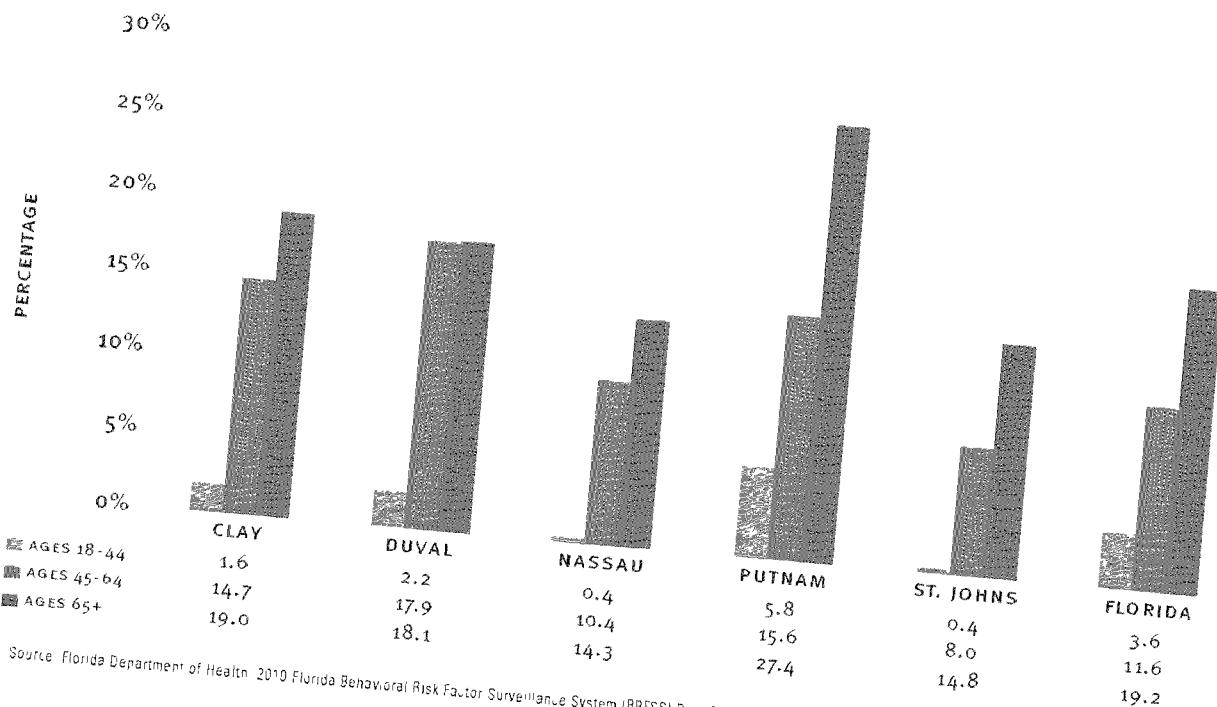


CHART 8-27 ADULTS WITH DIAGNOSED DIABETES, BY RACE

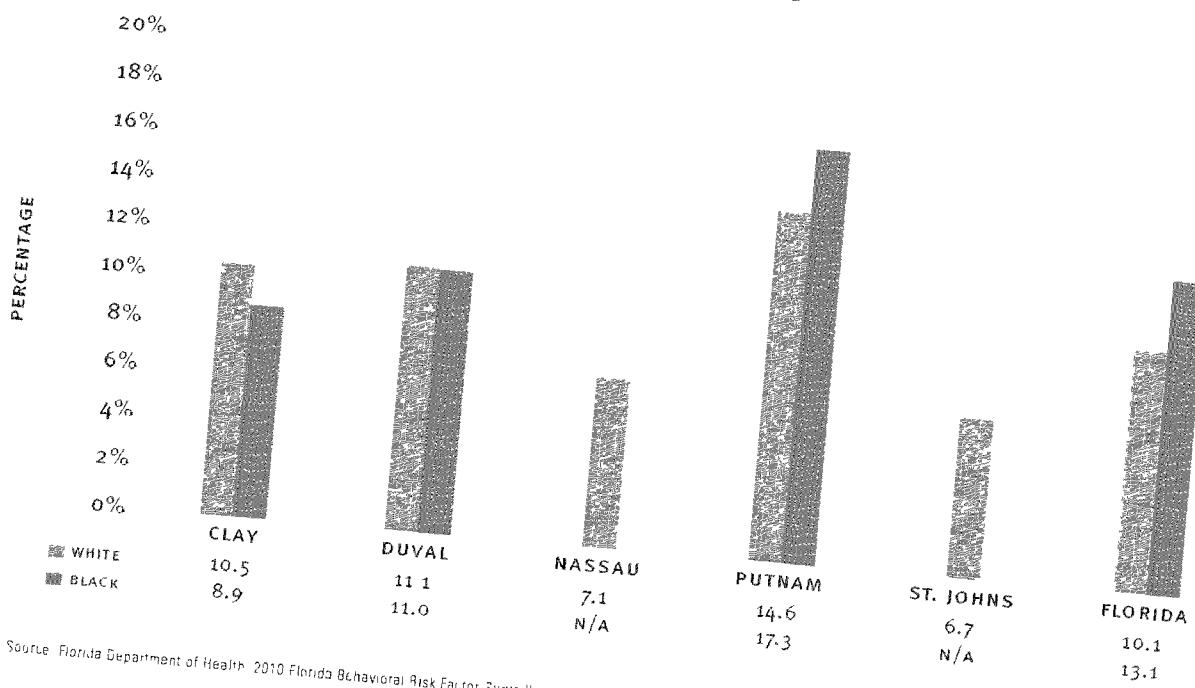
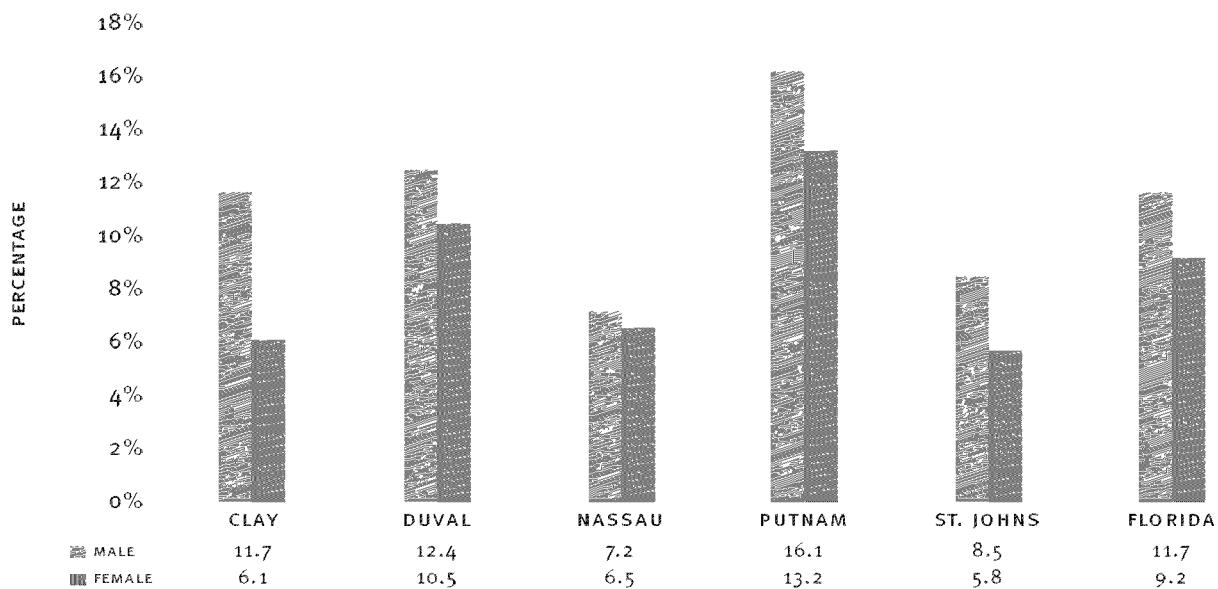
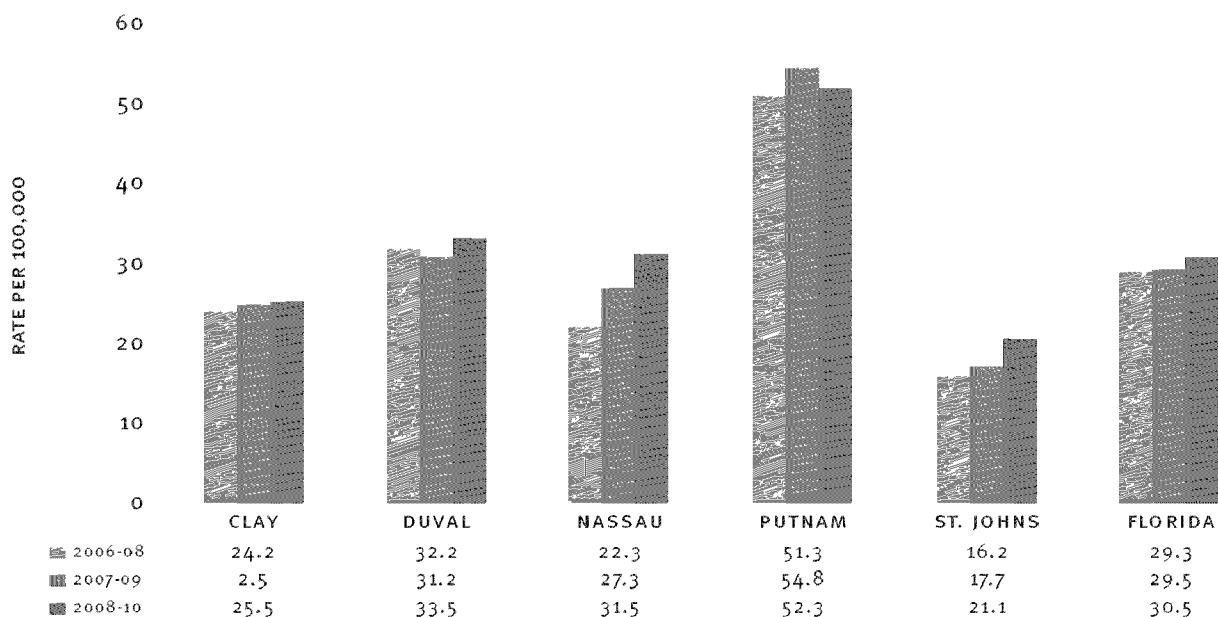


CHART 8-28 ADULTS WITH DIAGNOSED DIABETES, BY GENDER



Source: Florida Department of Health 2010 Florida Behavioral Risk Factor Surveillance System (BRFSS) Data Report

CHART 8-29 HOSPITALIZATIONS FROM AMPUTATION OF A LOWER EXTREMITY, ATTRIBUTABLE TO DIABETES



Source: Florida Agency for Health Care Administration (AHCA)

TABLE 8-1 DEATHS FROM HYPERTENSION (PER 100,000)

LOCATION	WHITE	BLACK	HISPANIC
CLAY	13.3	15.1	N/A
DUVAL	7.4	15.8	N/A
NASSAU	4.1	N/A	N/A
PUTNAM	12.6	25.6	N/A
ST. JOHNS	7	17.4	N/A
FLORIDA	5.5	15.4	4.5

Source: Florida Department of Health Bureau of Vital Statistics

TABLE 8-2 ADULTS WITH DIAGNOSED HYPERTENSION

LOCATION	WHITE	BLACK	HISPANIC
CLAY	30.4%	23.9%	N/A
DUVAL	33.8%	44.4%	N/A
NASSAU	37.7%	N/A	N/A
PUTNAM	42.6%	34.0%	N/A
ST. JOHNS	31.4%	N/A	N/A
FLORIDA	35.4%	41.7%	24.8%

Source: Florida Department of Health 2010 Florida Behavioral Risk Factor Surveillance System (BRFSS) Data Report

BEHAVIORAL HEALTH

For decades, behavioral health disciplines have existed alongside primary health care. However, in recent years there has been greater recognition of the link between good behavioral health and good overall health. The relationship between mental and physical health is bidirectional: mental disorders can have an effect on physical health and many physical ailments can induce more behavioral health issues.¹³ Thus, it is crucial to include behavioral health indicators in this assessment.

All five counties reported satisfaction with quality of life above 85 percent ("satisfied" or "very satisfied"). Putnam County residents reported the lowest satisfaction with quality of life, with 88.2 percent responding "satisfied" or "very satisfied." Nassau County residents gave the highest percentage of these responses (96.4 percent). Putnam County also showed the lowest levels of overall positive perception of their health and behavioral health. Respondents from St. Johns County had the highest percentages in these two indicators. See Chart 8-30 for levels of residents from every county in the assessment region. Chart 8-31 shows adults with good behavioral health by race. Overall, Black respondents had higher behavioral health satisfaction than White

13 World Federation for Mental Health. *World Mental Health Day* <http://www.wfmh.org/WMHD%2009%20Languages/ENGLISH%20WMHD09.pdf>

respondents, but this is not the case in Nassau County St. Johns County did not have data to report for Black respondents. Additionally, survey respondents overwhelmingly rated their behavioral health as positive (80 percent rated "good" or "excellent")

increased across the board. Nassau County has seen the most drastic increase and has the highest rate in the region. Chart 8-32 outlines the differences in the increases across counties and in the state of Florida even if they felt okay sometimes. Suicide rates have

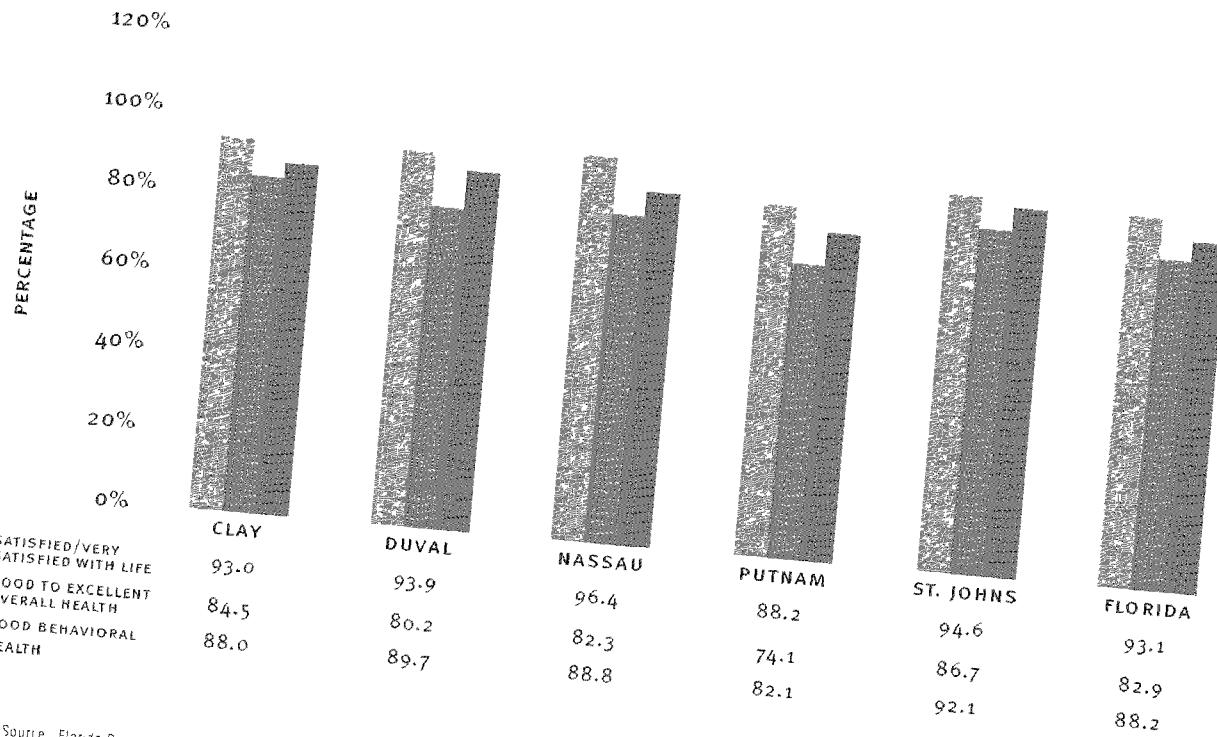
Psychiatric beds for adults have stayed about the same in Duval and St. Johns Counties, as well as the state of Florida. Clay County is the only county to show an increase. Nassau and Putnam Counties reported no adult psychiatric beds (see Chart 8-33). Duval County is the only county that provides child and adolescent psychiatric beds, and they do so at a rate similar to that of the state (see Chart 8-34).

Sixty-two percent of survey respondents have insurance that covers behavioral health services. It is important to note that 31 percent of respondents were "not sure" if their insurance covers behavioral health services. Behavioral health services were listed (albeit less frequently than other services) as being delayed in the last 12 months

Key Findings

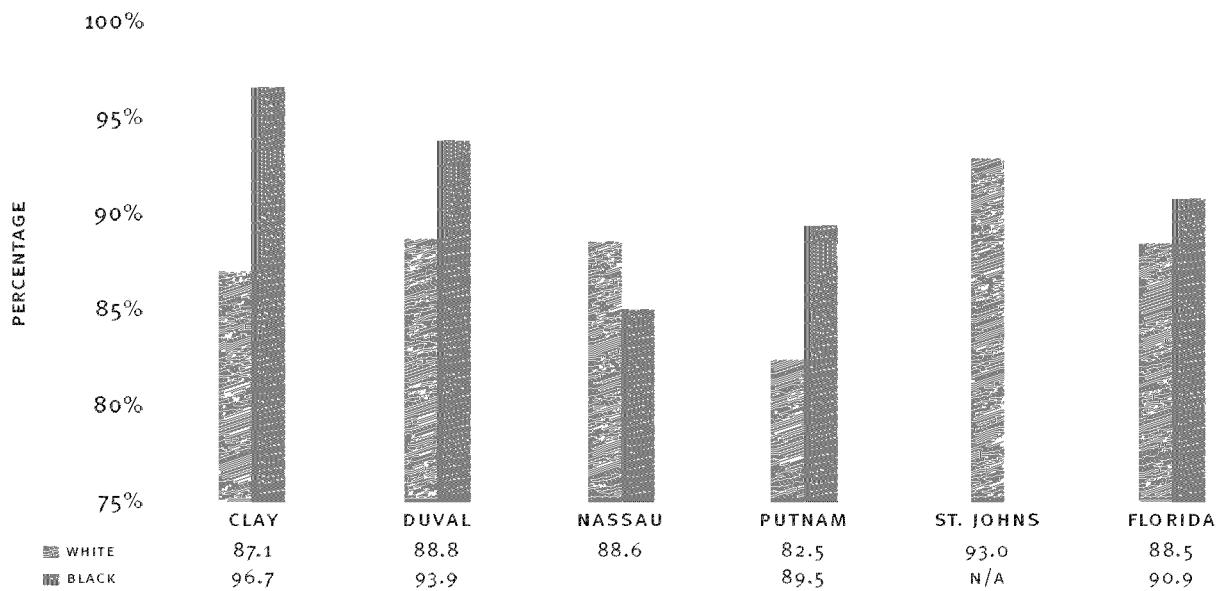
- All five counties reported satisfaction with life above 85 percent ("satisfied" or "very satisfied"). Putnam County residents reported the lowest satisfaction with quality of life, with 88.2 percent responding "satisfied" or "very satisfied." Nassau County residents gave the highest percentage of these responses (96.4 percent)
- Twenty-eight percent of survey respondents said they have had two years or more in their life when they felt depressed or sad most days, even if they felt okay sometimes.
- Suicide rates have increased across the board. Nassau County has seen the most drastic increase and has the highest rate in the region. Nassau and Putnam Counties reported no adult psychiatric beds

CHART 8-30 ADULTS REPORTING POSITIVE QUALITY OF LIFE



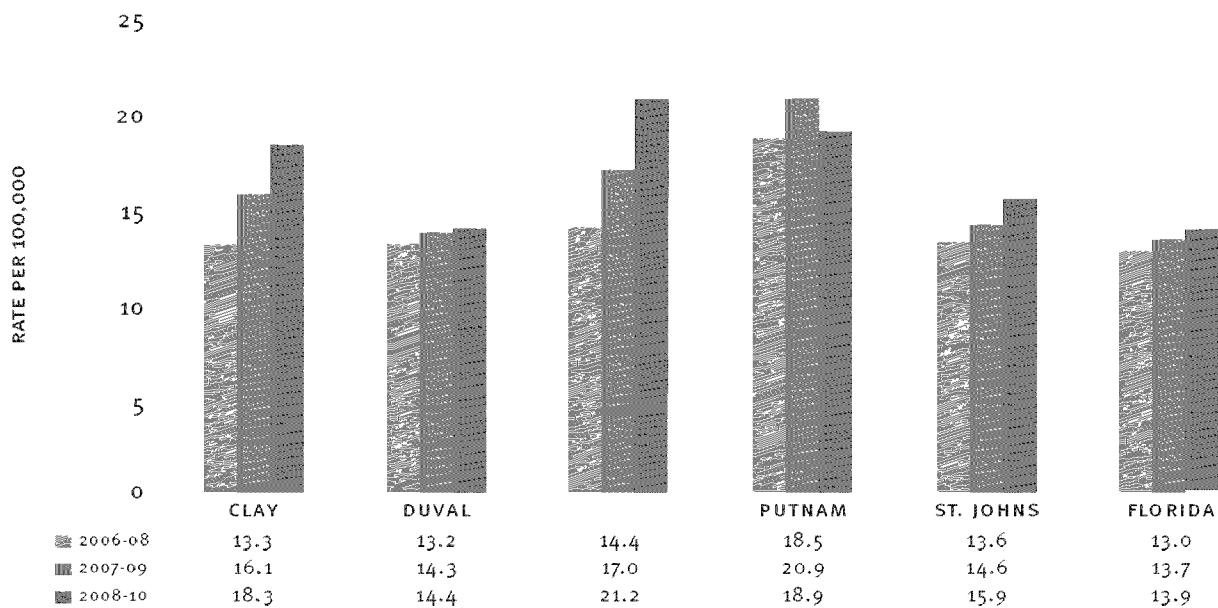
SOURCE: Florida Department of Health. 2010 Florida Behavioral Risk Factor Surveillance Survey (BRFS)

CHART 8-31 ADULTS WITH GOOD BEHAVIORAL HEALTH



Source: 2010 Florida Behavioral Risk Factor Surveillance Survey (BRFSS)

CHART 8-32



Source: Florida Department of Health Bureau of Vital Statistics

CHART 8-33 ADULT PSYCHIATRIC BEDS

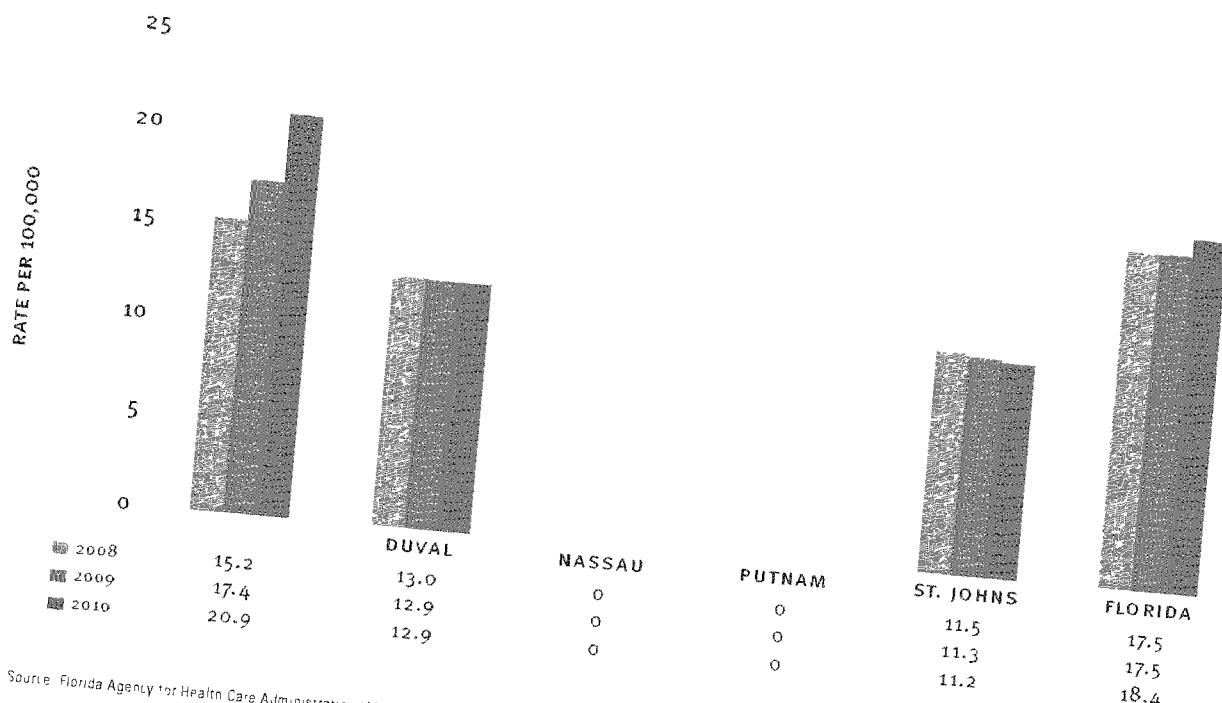
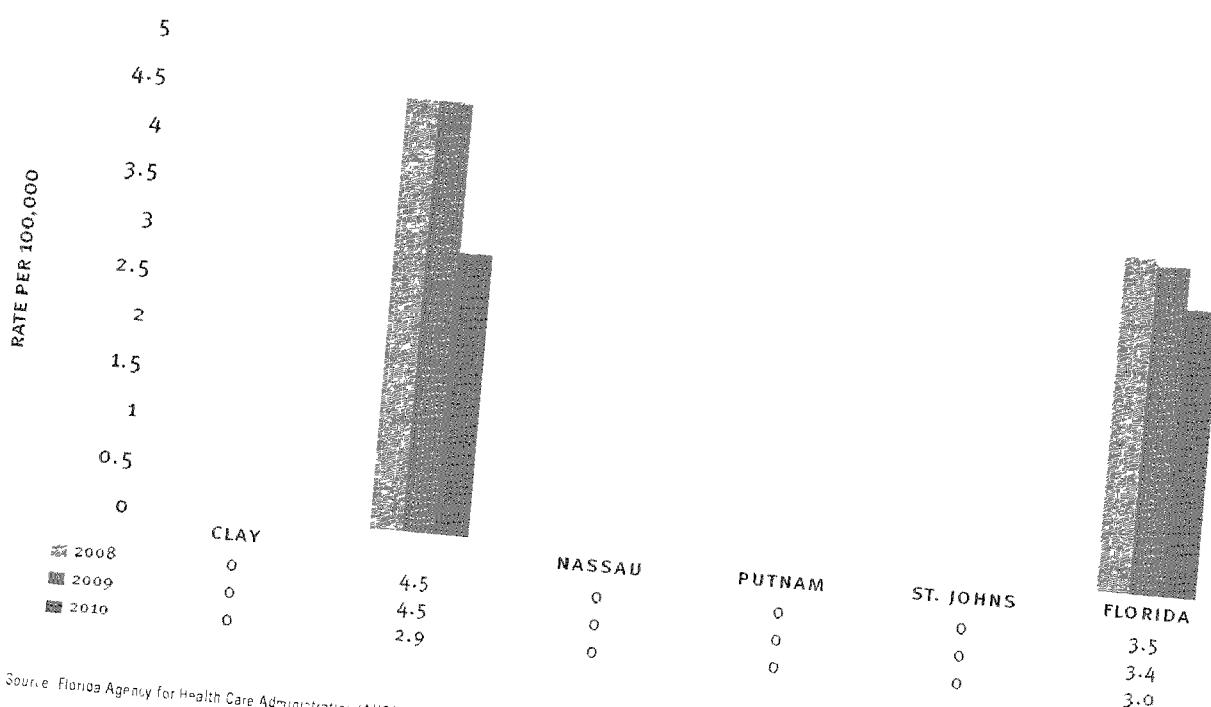


CHART 8-34 CHILD AND ADOLESCENT PSYCHIATRIC BEDS



SUBSTANCE ABUSE

Substance abuse is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress.¹⁴ Survey respondents listed drug abuse as a concerning unhealthy behavior with the second highest percentage of “very concerned” responses. However, the number of substance abuse beds does not mirror the concern of residents. In fact, only Duval County provides any of these beds (see Chart 8-35).

Smoking

Putnam County has the highest percentage of current smokers in the assessment region (23.6 percent). Percentages for males are higher than for females in Putnam and Duval Counties. In all other counties, the difference between genders is very small. See Chart 8-36 for details. Survey respondents were not too concerned with tobacco use, and gave the third lowest percentage of “very concerned” responses (38 percent “very concerned” responses). Thirteen percent of survey respondents smoke cigarettes “every day” or “some days.” Nine percent of respondents smoke every day.

Student cigarette use is higher among high school students than middle school students in all counties. The middle school percentage is highest in Putnam County (12 percent) and the highest percentage of high school smokers are in Clay County (19.4 percent). High school cigarette use has increased since 2008 in Clay and Duval Counties, but has decreased in all other counties in the assessment region and the state of Florida (see Chart 8-38). High school students use smokeless tobacco less than cigarettes, however the percentages in Clay and Nassau Counties are nearly double that of the state level (Chart 8-39).

Alcohol

Binge drinking among adults had declined in all counties except for St. Johns. The levels in Clay, Duval and St. Johns Counties are above the state level of 15 percent (Chart 8-40). In the survey, binge drinking was defined as five or more drinks in one sitting for males and four or more drinks in one sitting for females. Nineteen percent of respondents binge drank at least once in the past month. Eight percent did so three or more times. Eighty percent of respondents did not binge drink in the past month.

Key Findings

- The percentage of current smokers is high in comparison to the state level in nearly every county in the assessment region.
- High school cigarette use has increased since 2008 in Clay and Duval Counties, but has decreased in all other counties in the assessment region and the state of Florida.
- High school students use smokeless tobacco less than cigarettes, however its use has almost doubled in Clay, Nassau and St. Johns Counties.
- Binge drinking among adults has declined in all counties except for St. Johns County. The levels in Clay, Duval and St. Johns Counties are above the state level of 15 percent.

¹⁴ University of Indiana DSM-IV Substance Abuse Criteria <http://www.sis.indiana.edu/DSM-IV-Criteria.aspx>

CHART 8-35 ADULT SUBSTANCE ABUSE BEDS

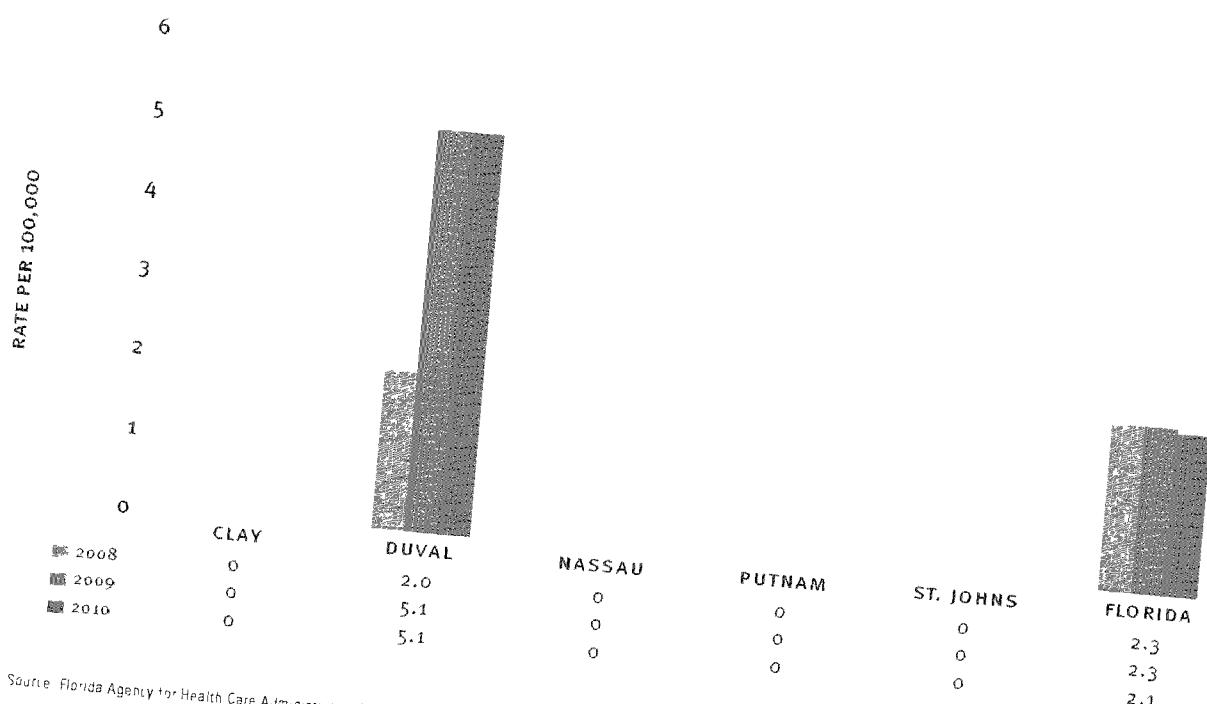


CHART 8-36 CURRENT SMOKERS, BY GENDER

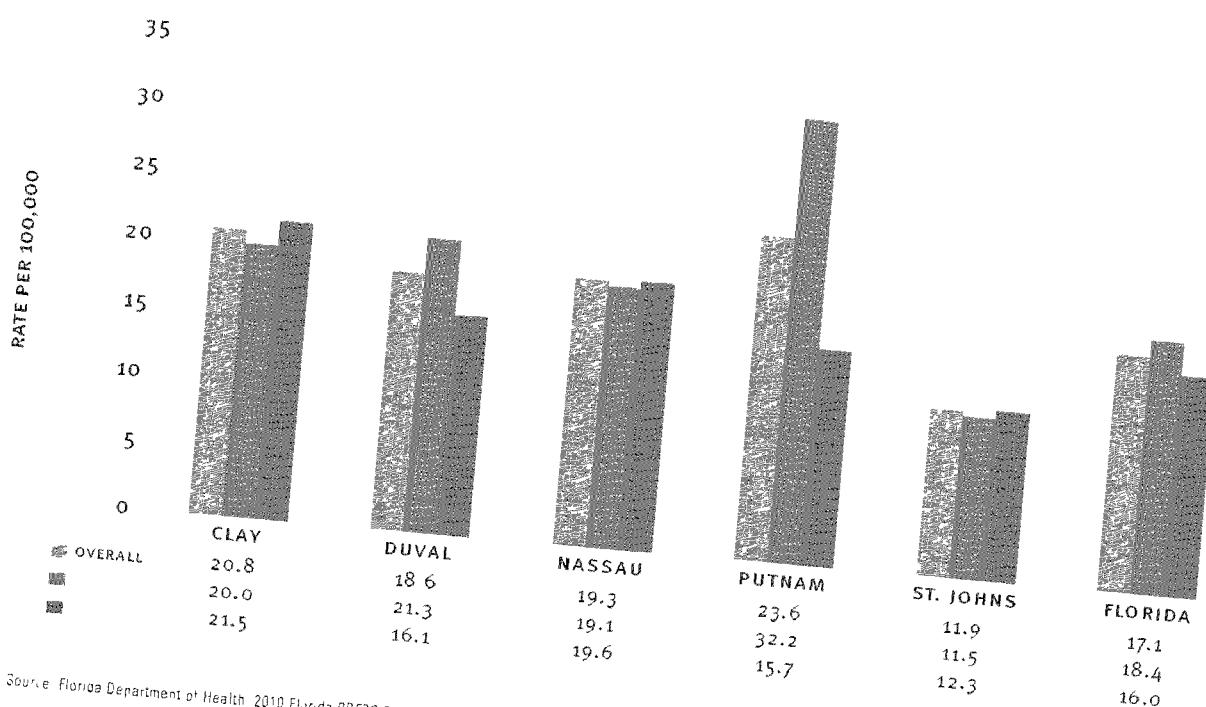
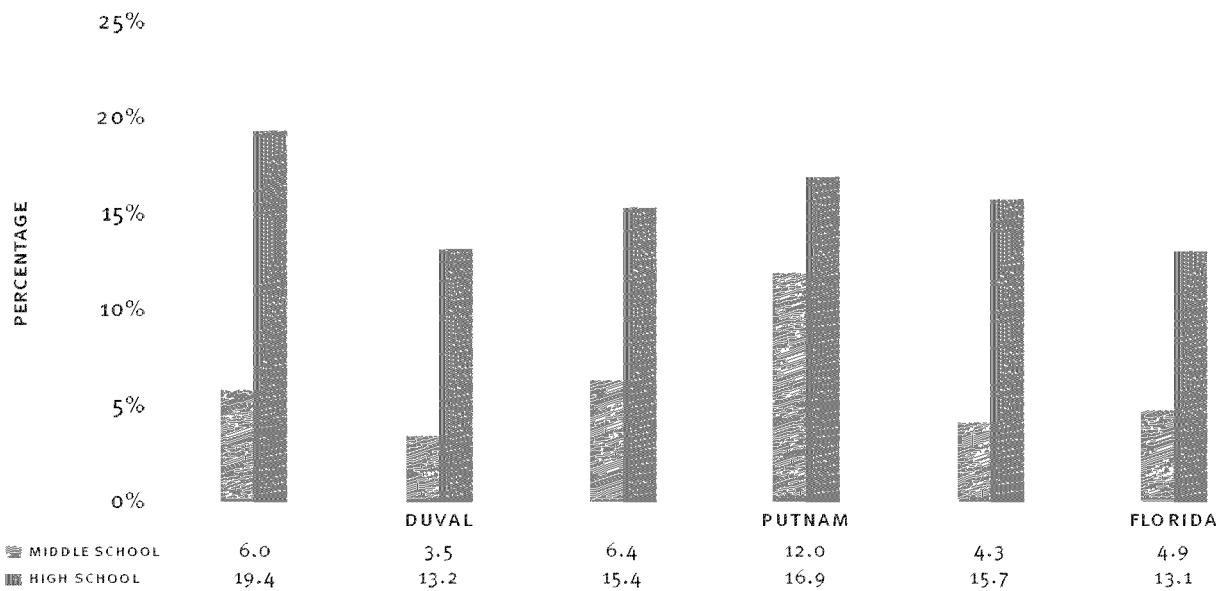
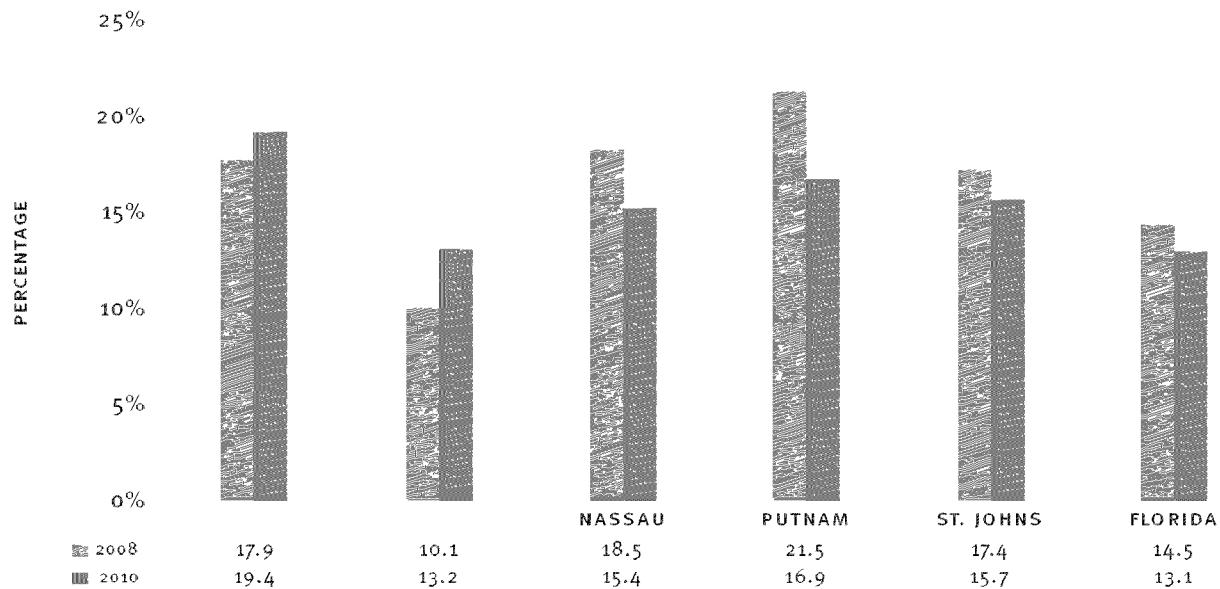


CHART 8-37 STUDENT CIGARETTE USE



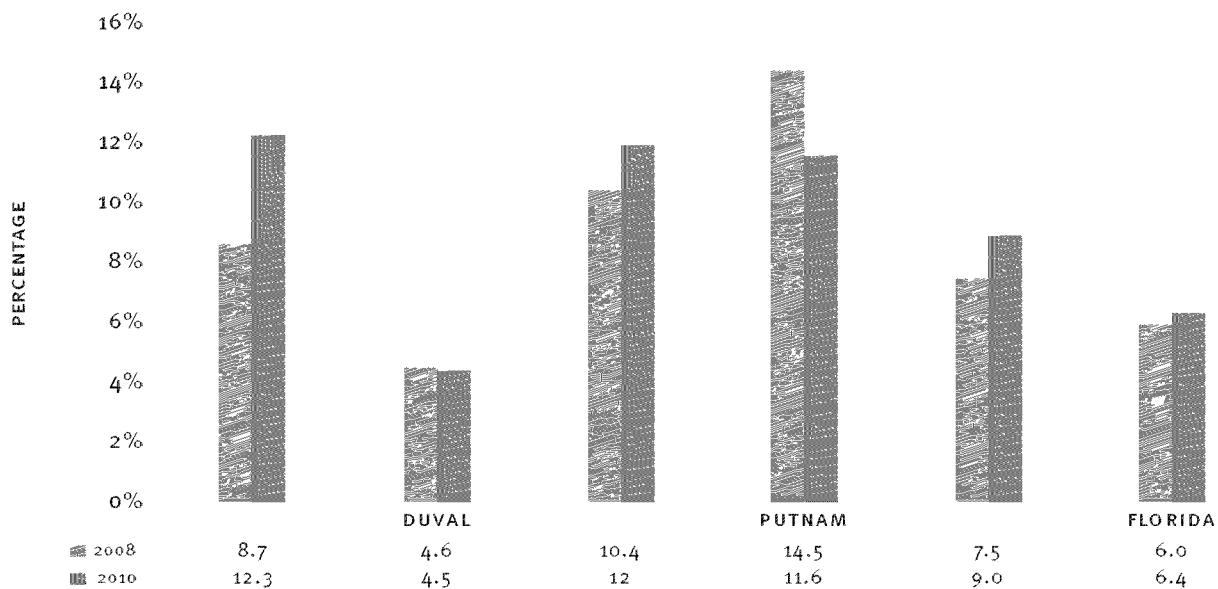
Source: Florida Department of Health, Florida Youth Tobacco Survey

CHART 8-38 HIGH SCHOOL STUDENT CIGARETTE USE



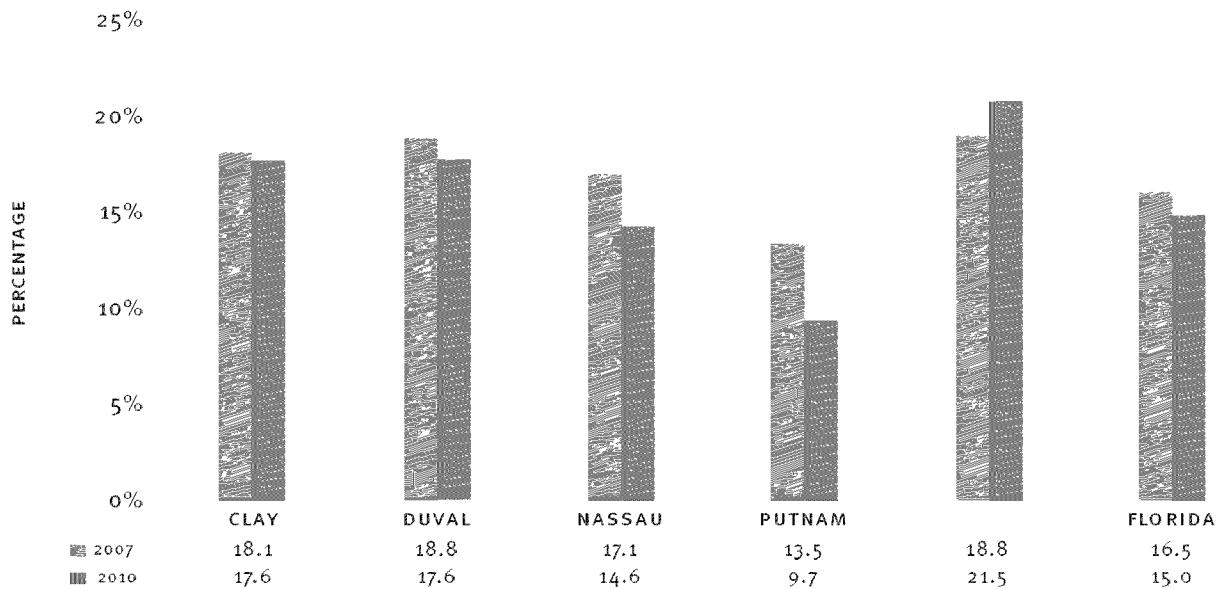
Source: Florida Youth Tobacco Survey

CHART 8-39 HIGH SCHOOL STUDENT SMOKELESS TOBACCO USE



Source: Florida Youth Tobacco Survey

CHART 8-40 BINGE DRINKING AMONG ADULTS



Source: Florida Department of Health 2007 and 2010 Florida Behavioral Risk Factor Surveillance Survey (BRFSS)

OBESITY

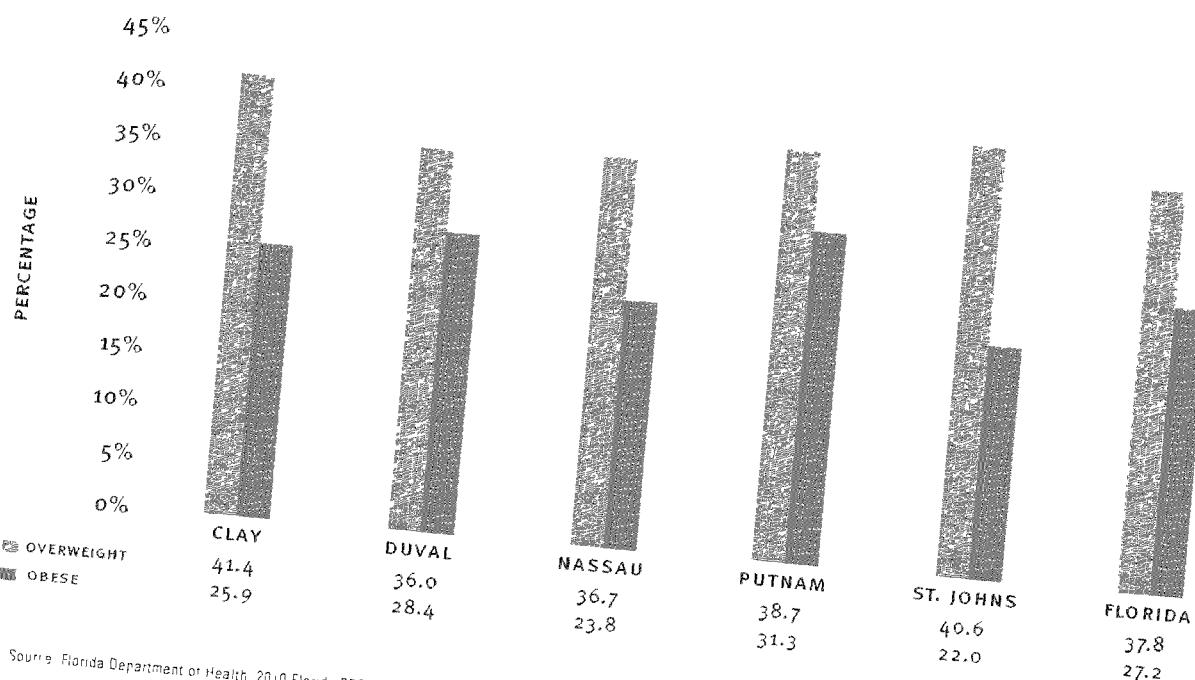
Percentages of overweight individuals are higher than those of obese residents across the board. The levels of overweight people in Clay, Putnam and St. Johns Counties are above the state level of 37.8 percent. When analyzing obesity levels, Duval and Putnam Counties have percentages above the state level of 27.2 percent (see Chart 8-41). Survey data shows that

Obesity data for non-White residents is not available for all counties in the assessment region, but in the counties that do provide this data, Black residents have higher rates, with the exception of Putnam County (Chart 8-42). In the region and in the state, percentages of teens at or above the 95th percentile in BMI fall between 10 and 15 percent. St. Johns County is the exception with percentages much lower (see Chart 8-43). These rates are high despite focus group participants listing eating right and exercising (at the gym, walking the track at local schools, etc.) as ways that people in their communities stay healthy.

Key Findings

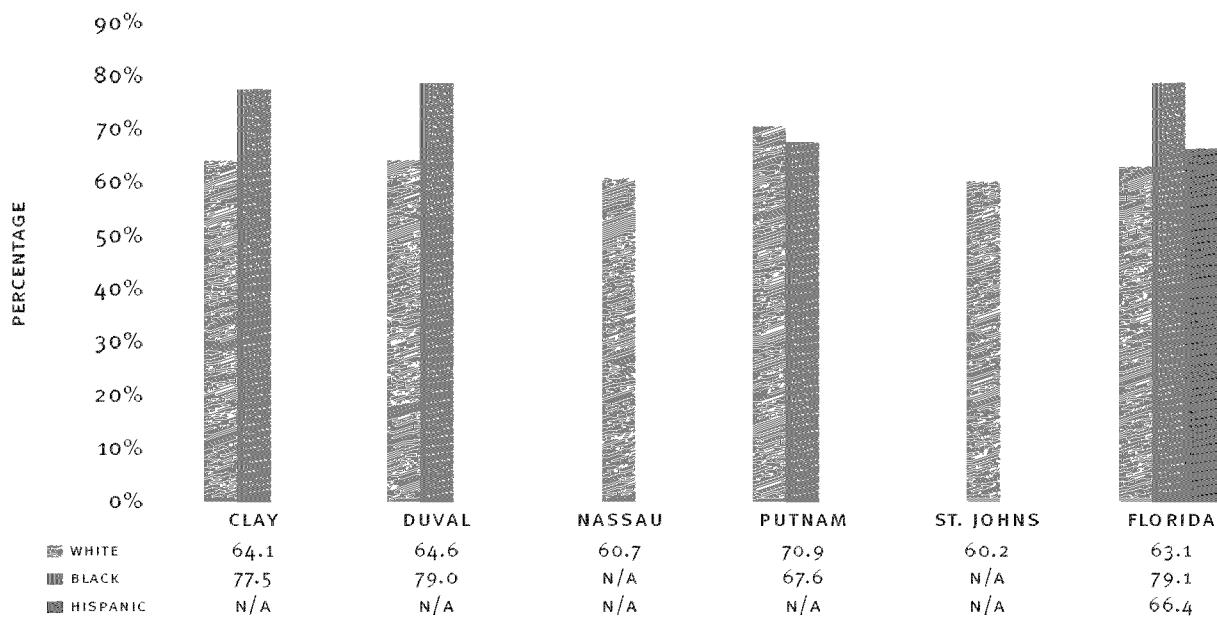
- The levels of overweight people in Clay, Putnam and St. Johns Counties are above the state level of 37.8 percent
- Duval and Putnam Counties have obesity levels above the state level of 27.2 percent (28.4 and 31.3 percent, respectively).
- Survey respondents viewed obesity as the most serious health problem in their communities
- In the region and in the state, percentages of teens at or above the 95th percentile in BMI fall between 10 and 15 percent. St. Johns County is the exception with percentages much lower
- Although focus group participants list eating right and exercising as ways people in their communities stay healthy, overweight and obesity rates are still greater than the state averages

CHART 8-41 OVERWEIGHT AND OBESE ADULTS

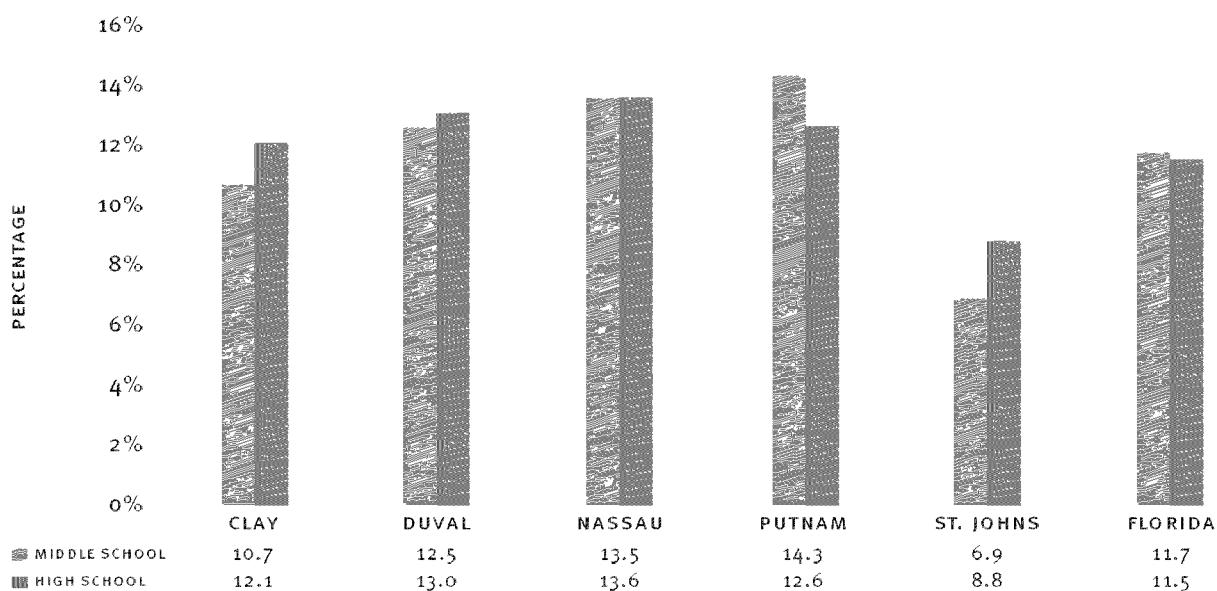


Source: Florida Department of Health 2010 Florida BRFGS Data Report

CHART 8-42 OVERWEIGHT AND OBESE ADULTS, BY RACE



Source: Florida Department of Health 2010 Florida BRFSS Data Report

CHART 8-43 OVERWEIGHT TEENS – BMI AT OR ABOVE 95TH PERCENTILE

Source: Florida Department of Health School aged Child and Adolescent Profile

SEXUALLY TRANSMITTED DISEASES

Syphilis, Gonorrhea, Chlamydia

The rate per 100,000 for infectious syphilis is well below the state level in all but Duval County. In fact, the Duval County rate has been higher than the state level since 2008 and has been increasing. Levels of syphilis have dropped in Nassau, Putnam and St. Johns Counties (see Chart 8-44). Chart 8-45 illustrates the overall decline in gonorrhea cases reported in all counties in the assessment region. Still, rates in Duval and Putnam Counties lie above the state level. Chlamydia rates have been on the rise in all counties, and the 2010 rates in Duval and Putnam Counties are higher than the state level (see Chart 8-46).

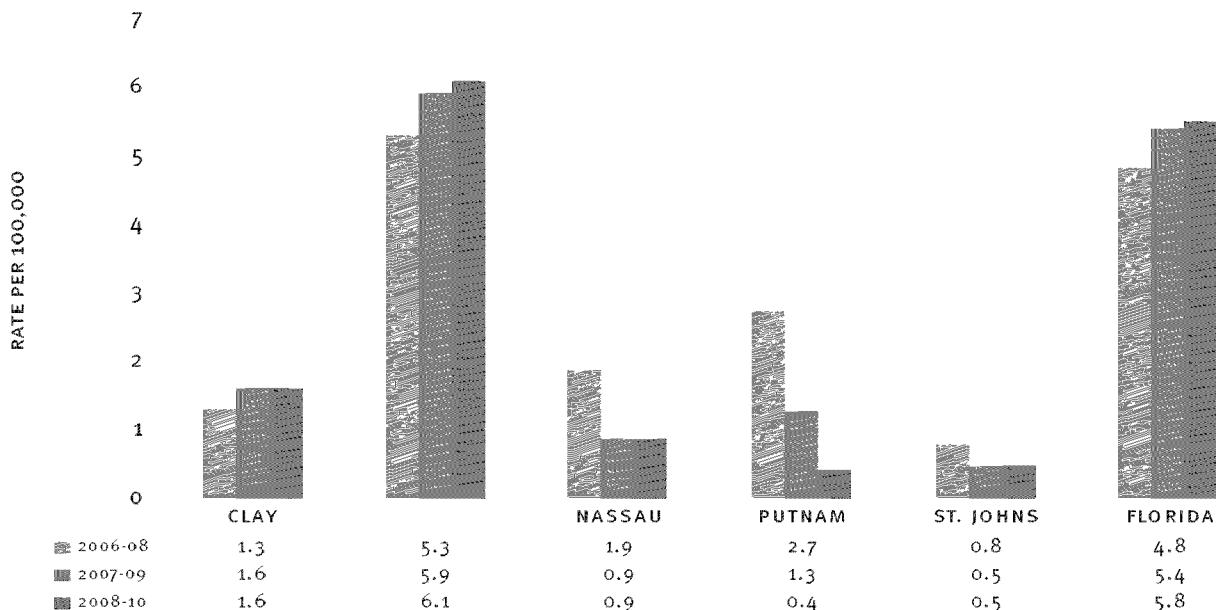
HIV/AIDS

Charts 8-47 and 8-48 outline the rates of new HIV and AIDS cases. For both new HIV and new AIDS cases, Duval County is the only county in the assessment region that has rates higher than the state of Florida. Clay, Nassau and St. Johns Counties have new HIV case rates under 15 percent. The rates of new AIDS cases in Clay and Putnam Counties have increased, while St. Johns County has decreased. Nassau County did not have data to report prior to the rolling rate for 2008 through 2010. The HIV/AIDS death rates have fallen or stayed the same in every county of the assessment region. See Chart 8-49 to compare county rates to the state's rate.

Key Findings

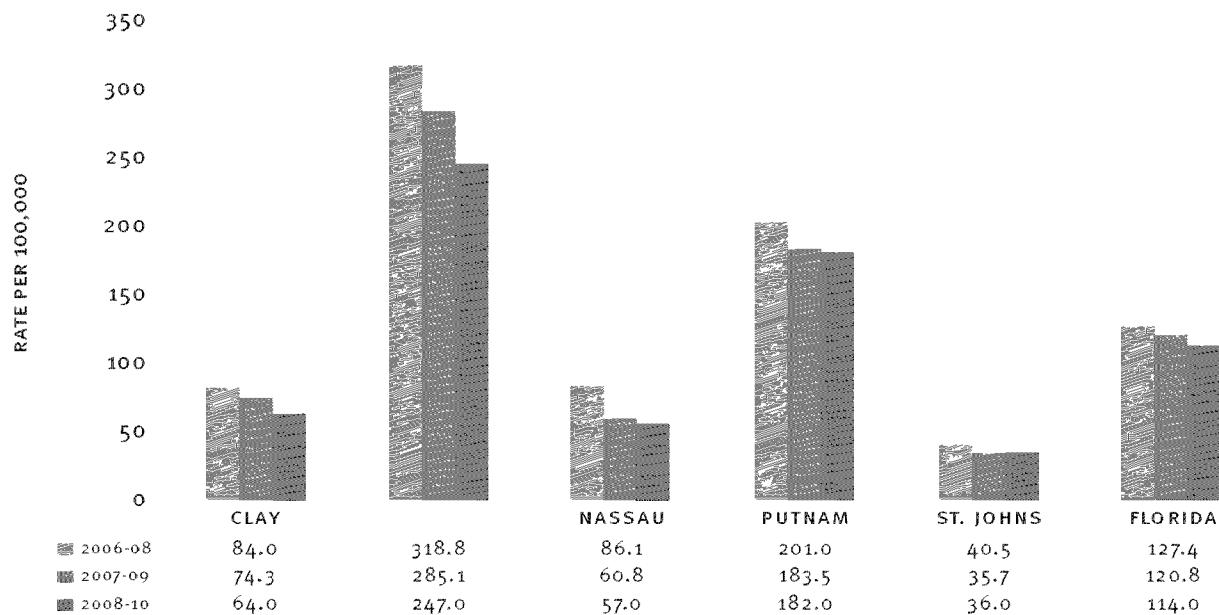
- The Duval County rate for infectious syphilis has been higher than the state level since 2008 and has been increasing. Levels of syphilis have dropped in Nassau, Putnam and St. Johns Counties.
- Chlamydia rates have been on the rise in all counties
- The HIV/AIDS death rates have fallen or stayed the same in every county of the assessment region

CHART 8-44 INFECTIOUS SYPHILIS CASES REPORTED



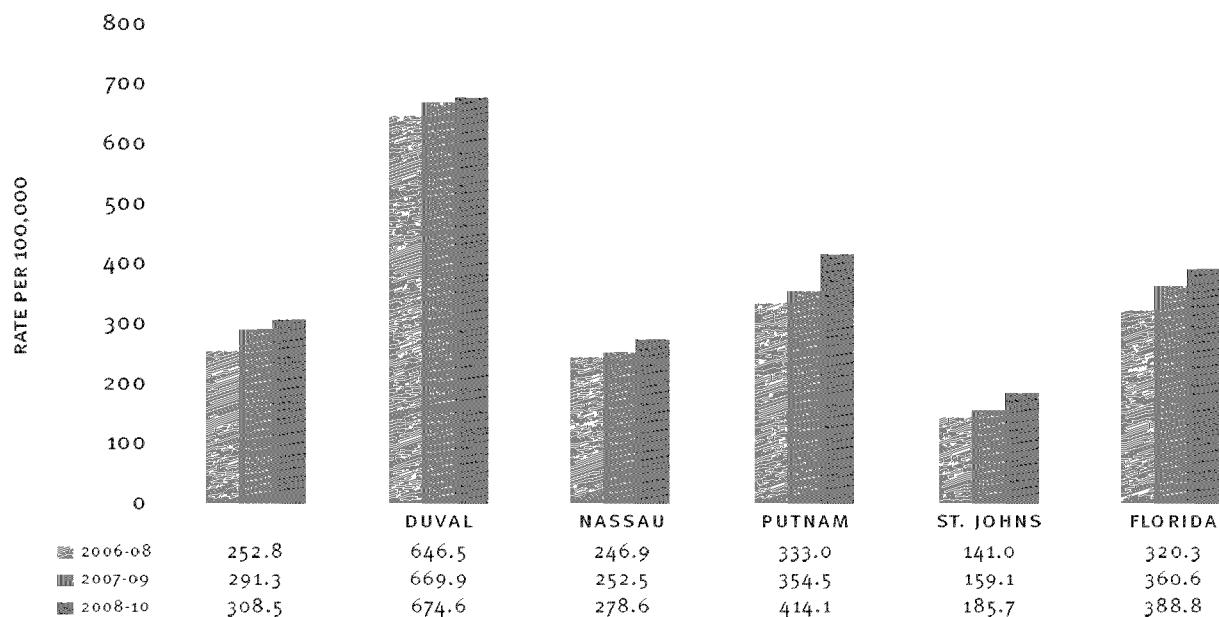
Source: Florida Department of Health, Bureau of STD Prevention & Control (CHARTS)

CHART 8-45 GONORRHEA CASES REPORTED



Source: Florida Department of Health, Bureau of STD Prevention & Control (CHARTS)

CHART 8-46 CHLAMYDIA CASES REPORTED



Source: Florida Department of Health, Bureau of STD Prevention & Control (CHARTS)

CHART 8-47 NEW HIV CASES REPORTED

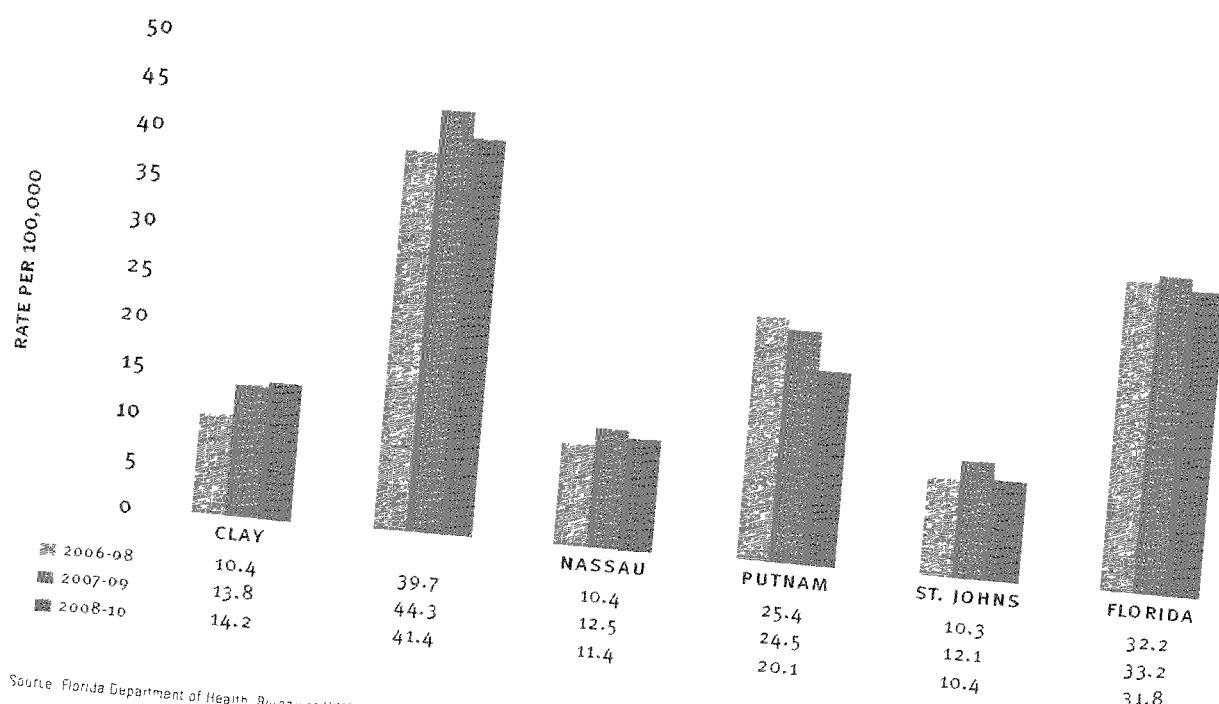


CHART 8-48 NEW AIDS CASES REPORTED

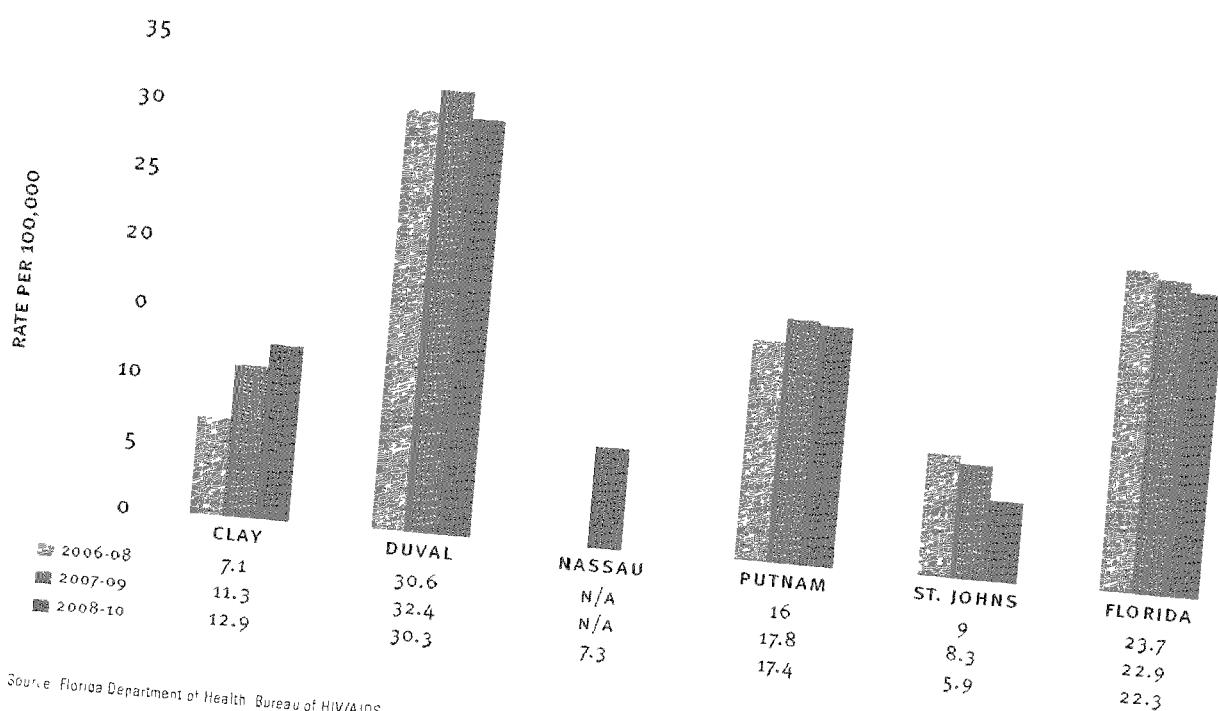
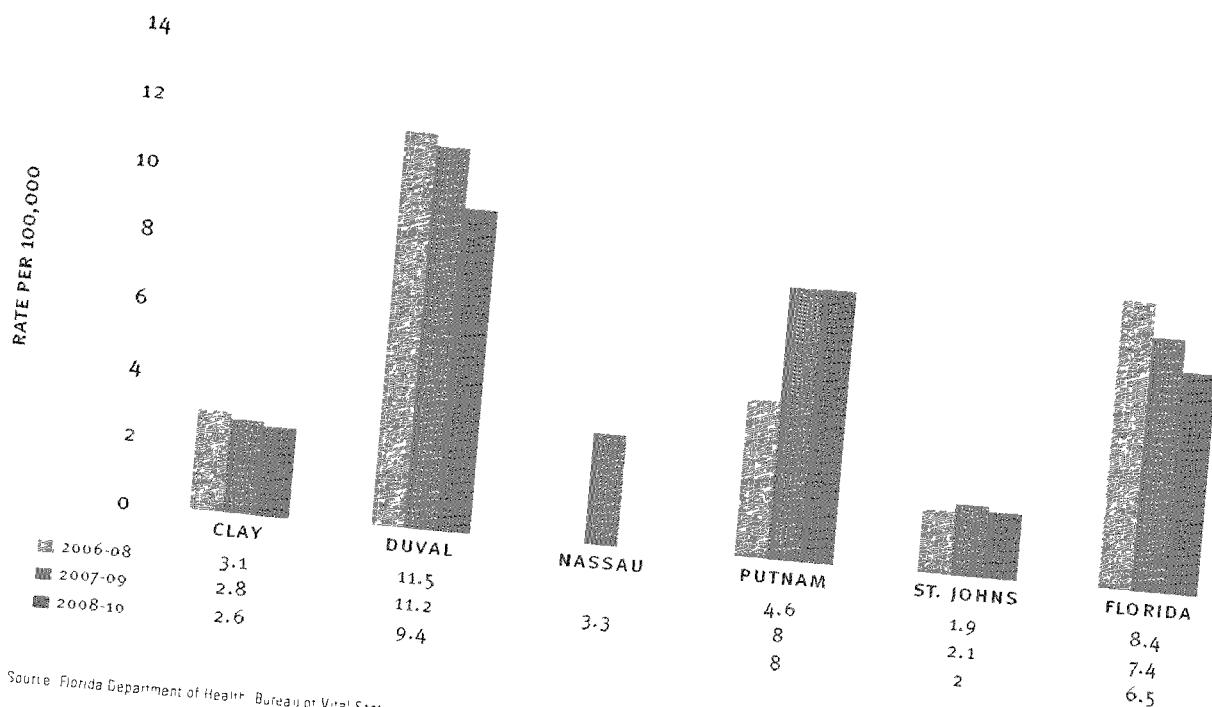


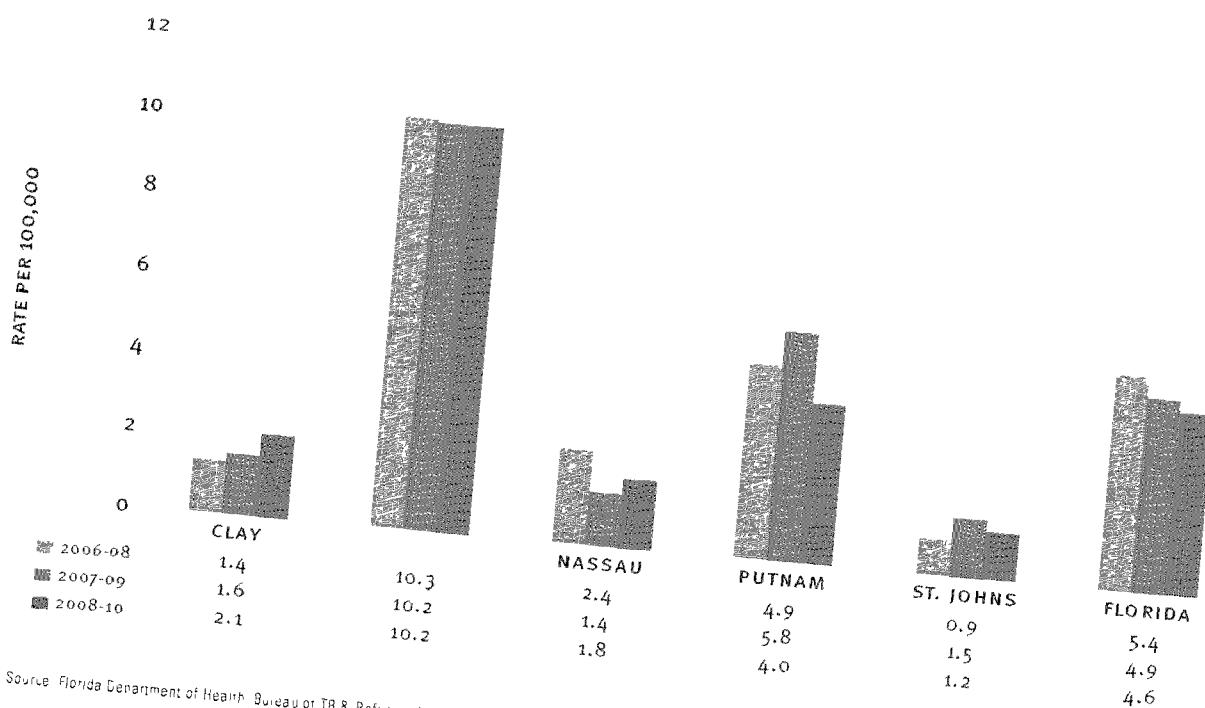
CHART 8-49 HIV/AIDS DEATH RATE



Infectious Diseases

The rate per 100,000 of tuberculosis in Duval County is more than double that of the state level (4.6 percent). The rates in Clay and St. Johns Counties have increased, while Duval, Nassau and Putnam Counties mirror the state in their decline. See Chart 8-50 for more information.

CHART 8-50 TUBERCULOSIS



MATERNAL AND INFANT HEALTH

Maternal and infant health are significant indicators of health and societal progression for future generations. Florida's statewide infant mortality rates (6.9 per 1,000 live births) for 2010 are slightly higher than the baseline rates indicated by *Healthy People 2020* objectives (6.7 infant deaths per 1,000 live births). The following data are from secondary data analysis for maternal and infant health.

Early Prenatal Care

The region's rate of births with prenatal care during the first trimester is comparable to the state percentage of 78.1 percent for 2010. Putnam County had the lowest percentage of 69.2 percent and also yielded the lowest percentage for Hispanic residents (60 percent). In addition, Duval County had the lowest percentage among Black residents (62.3 percent), which is much lower than the state rate of 70.1 percent.

Births with late or no prenatal care were the highest in Duval and Putnam Counties (6.7 and 6.9 percent, respectively) between 2008 and 2010 compared to the state percentage of 5.1 percent. All other counties were below the state percentage. Putnam County's rate of Hispanic births with late or no prenatal care was more than 70 percent higher than that of the state (9.5 and 5.5, respectively).

Infant Mortality

Infant mortality for the region remained relatively constant from 2006 through 2010 with only mild fluctuations. While Putnam County had higher percentages of births with little or no prenatal care, Duval County had the highest infant mortality rate for 2010 (8.8 per 1,000 live births) as compared to the state (6.9 per 1,000 live births). St. Johns and Clay Counties had the lowest rates (5.4 and 5.6 per 1,000 live births, respectively). In addition, infant mortality racial differences for the region were reported in Duval County only (13.1 Black and 7.5 Hispanic, respectively) and were higher than state rates (12.6 Black and 5.5 Hispanic, respectively). However, a decrease in infant mortality was reported from 2006 to 2010, with rates dropping from 9.7 to 7.5 for Hispanic residents in Duval County.

Preterm Births

Duval County has a high rate of neonatal intensive care beds compared to the state. All other counties remain lower than the state rate (or had none reported). The per capita numbers of Level II and III beds for Duval County (9.3 and 6.2 per 100,000, respectively) are significantly higher than those of the state rate (5.0 and 3.7 per 100,000, respectively) for 2010.

Low Birth Weight Babies

The rate of low birth weight (less than 2,500g) babies was the highest in Duval and Putnam Counties (9.5 and 9.6 percent, respectively) between 2008 and 2010 and was higher than the state rate of 8.7 percent. St. Johns County had the lowest rate for the same time period (6.5 percent). In conjunction, highest percentages were reported in Black residents for all counties and were significantly higher in Nassau County (19.4 percent) compared to the state (13.6 percent).

Teen Mothers

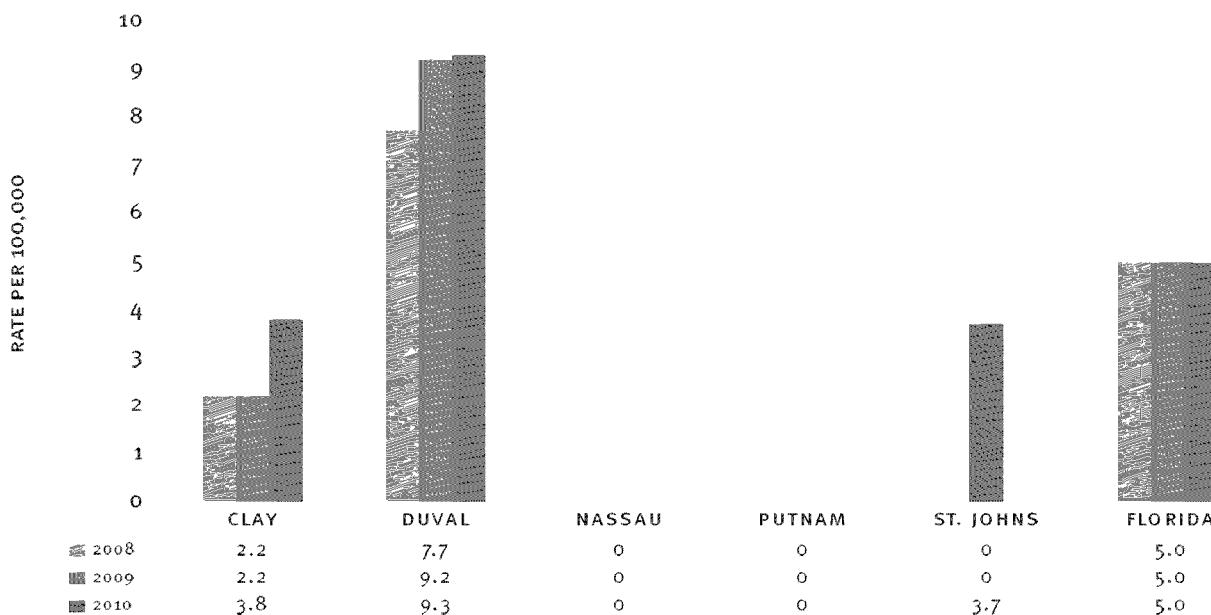
Putnam County had the highest rate of births to young mothers ages 15 to 19 between 2008 and 2010 (71.3 rate per 1,000 females), and was nearly double that of the state rate (37 rate per 1,000). In addition, Black and Hispanic residents showed the highest rates (98.1 and 85.8 per 1,000 females, respectively) and were also on the approximate order of double the state rates (57.2 and 42.2 rate per 1,000 females, respectively).

The rate of births to mothers ages 10 to 14 in Putnam County (1.7 rate per 1,000 females) was more than three times that of the state rate (0.5 rate per 1,000 females).

Key Findings

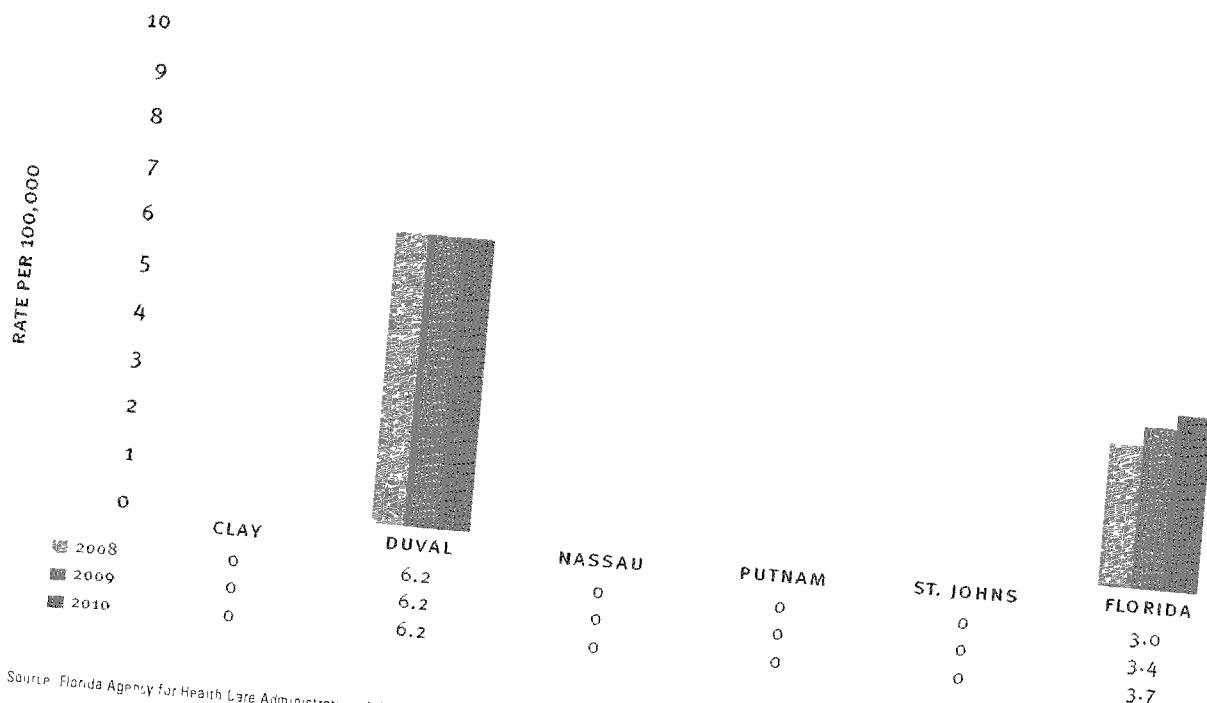
- The region's rate of births with prenatal care during the first trimester is comparable to the state percentage
- Putnam County had the lowest percentage of births with prenatal care in the first trimester
- Putnam County had the lowest percentage of births with prenatal care for Hispanic residents
- Duval County had the lowest percentage of births with prenatal care among Black residents
- Duval County had the highest infant mortality rate for 2010
- St. Johns and Clay Counties had the lowest infant mortality rate for 2010
- Infant mortality racial differences for the region were reported in Duval County only
- A decrease in infant mortality was reported from 2006 to 2010 for Hispanic residents in Duval County
- Duval County has a high rate of neonatal intensive care beds compared to the state
- The rate of low birth weight (less than 2,500g) babies was the highest in Duval and Putnam Counties
- The rate of low birth weight (less than 2,500g) babies was the greatest in Black residents for all counties
- The rate of low birth weight (less than 2,500g) babies was highest in Nassau County for Black residents
- Putnam County had the highest rate of births to young mothers ages 15 to 19 between 2008 and 2010
- Putnam County had the highest rate of births to young mothers ages 15 to 19 between 2008 and 2010 for Black and Hispanic residents
- Putnam County had the highest rate of births to young mothers ages 10 to 14

CHART 8-51 NEONATAL INTENSIVE CARE UNIT LEVEL II BEDS



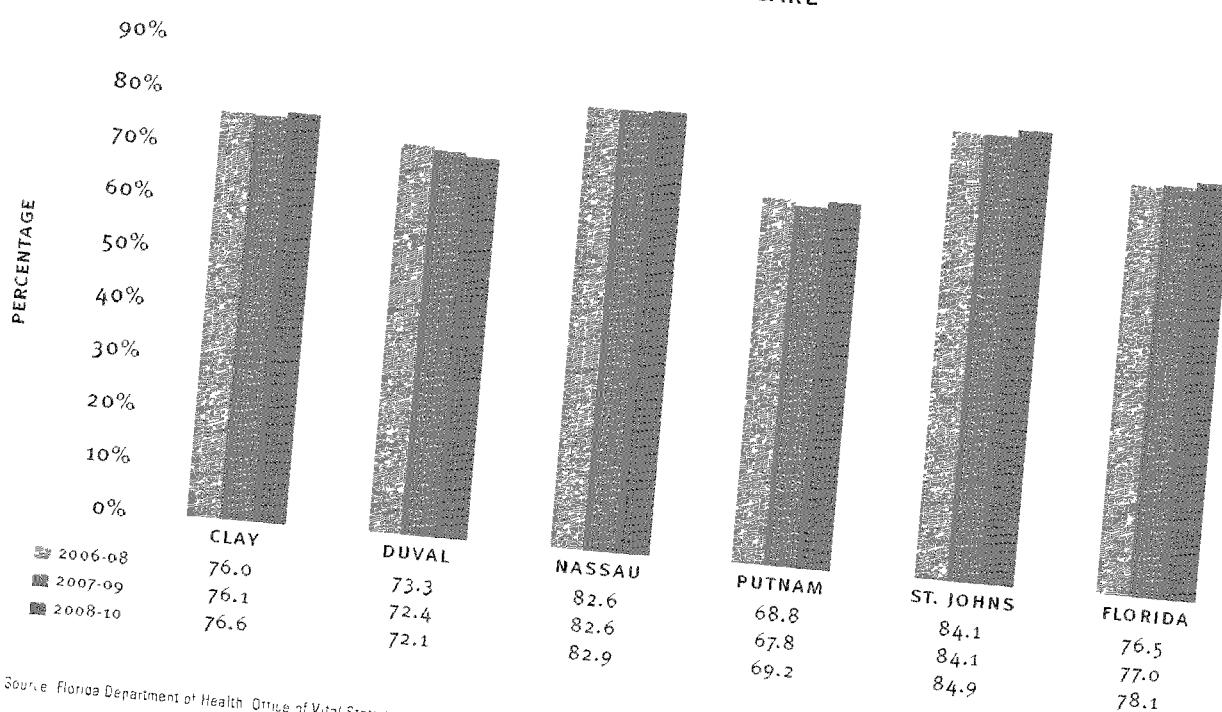
Source: Florida Agency for Health Care Administration (AHCA)

CHART 8-52 NEONATAL INTENSIVE CARE UNIT LEVEL III BEDS



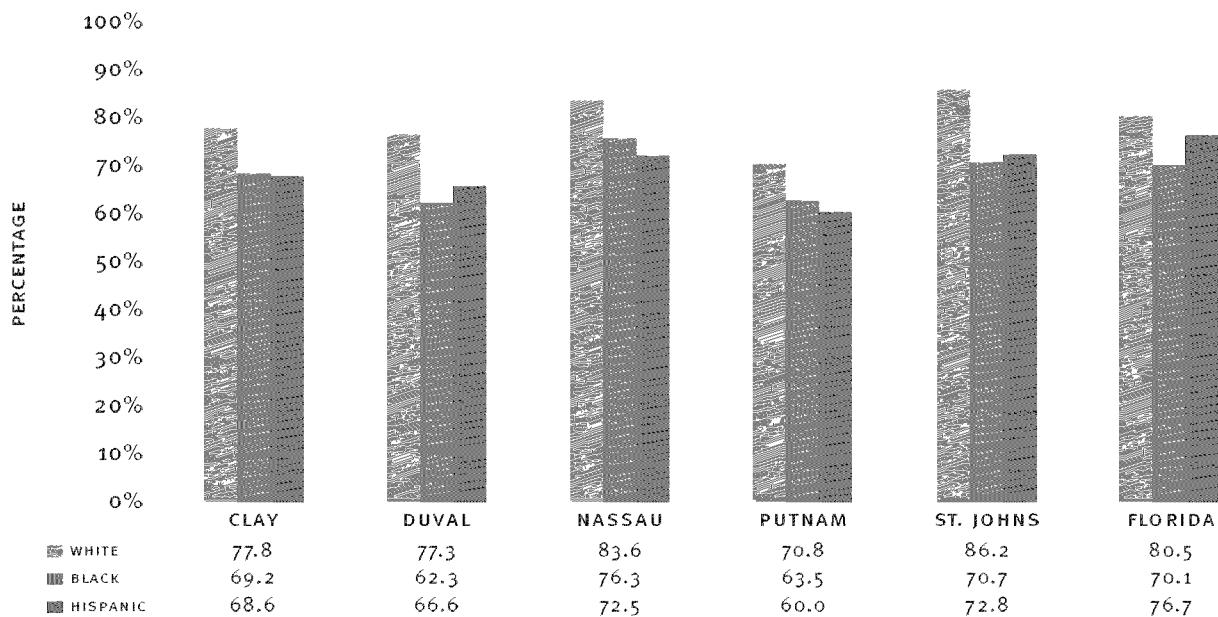
Source: Florida Agency for Health Care Administration (AHCA)

CHART 8-53 BIRTHS WITH FIRST TRIMESTER PREGNATAL CARE



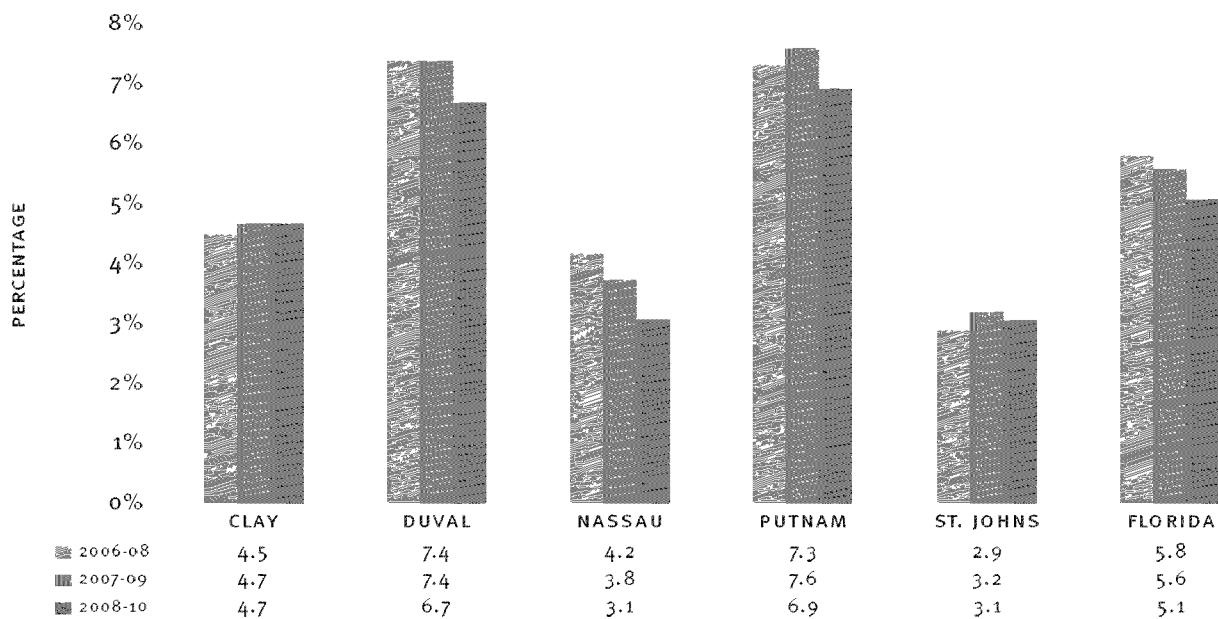
Source: Florida Department of Health, Office of Vital Statistics, 2006-2010

CHART 8-54 BIRTHS WITH FIRST TRIMESTER PREGNATAL CARE, BY RACE



Source: Florida Department of Health Office of Vital Statistics, 2008-2010

CHART 8-55



Source: Florida Department of Health Office of Vital Statistics, 2006-2010

CHART 8-56 BIRTHS WITH LATE OR NO PRENATAL CARE, BY RACE

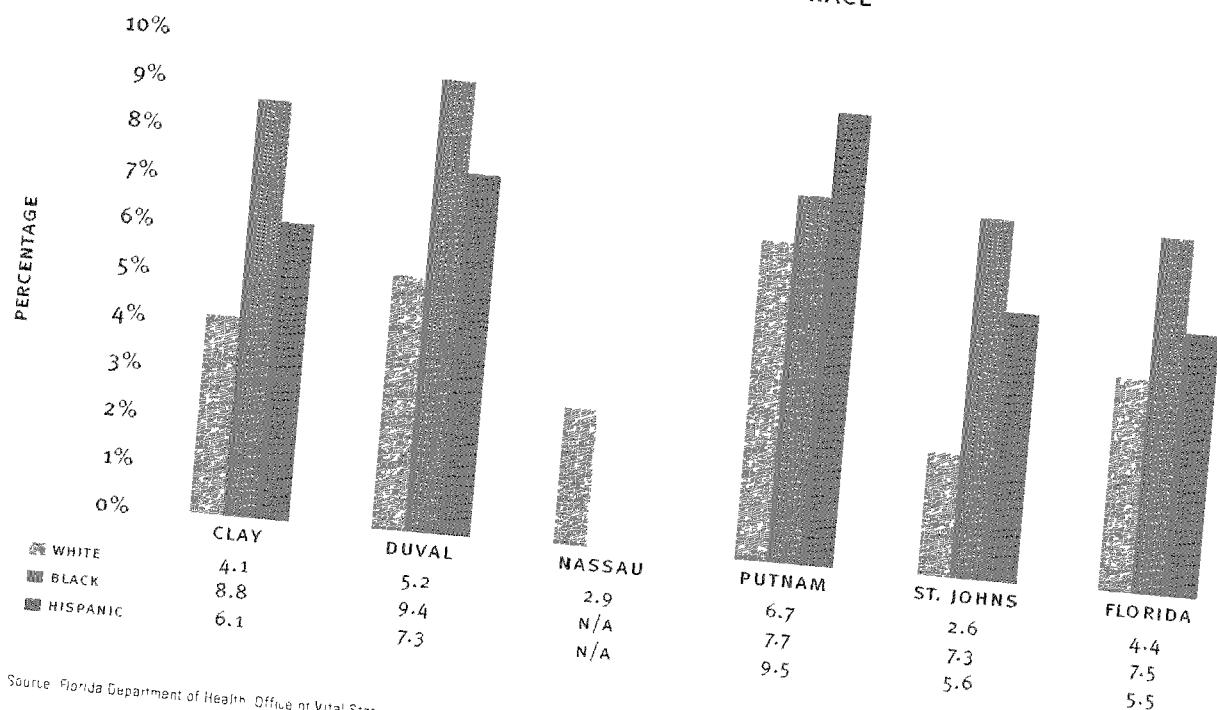


CHART 8-57 INFANT MORTALITY

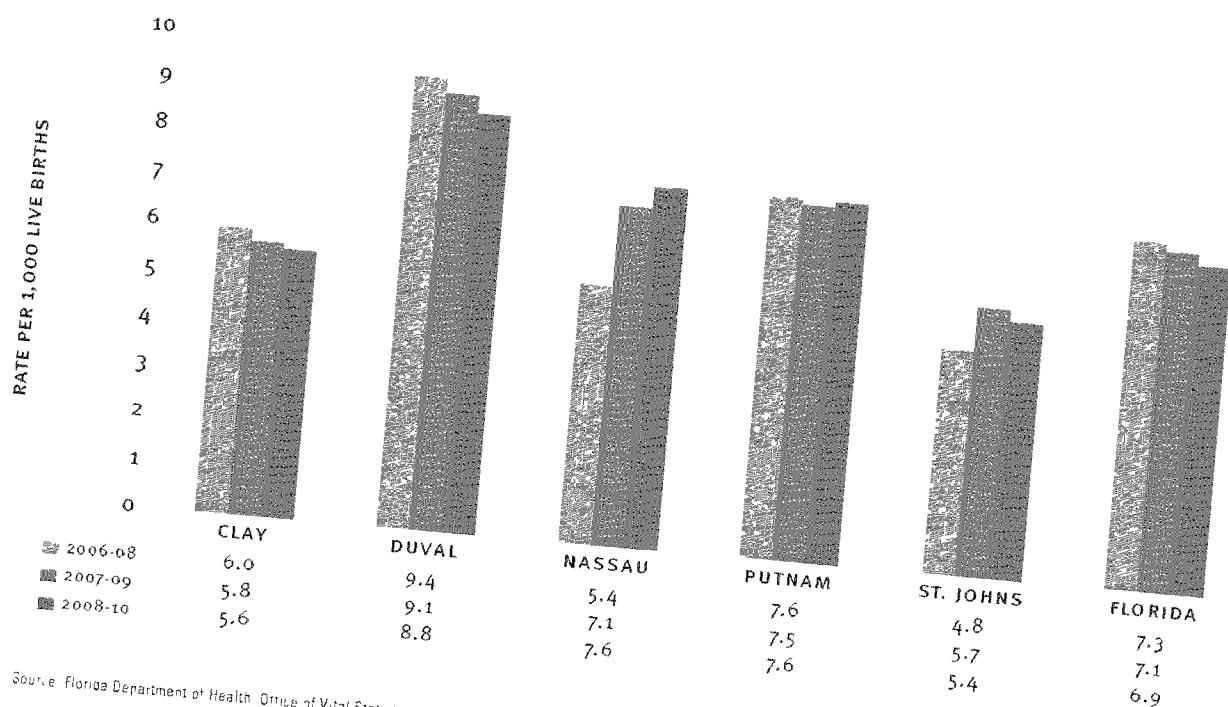


CHART 8-58

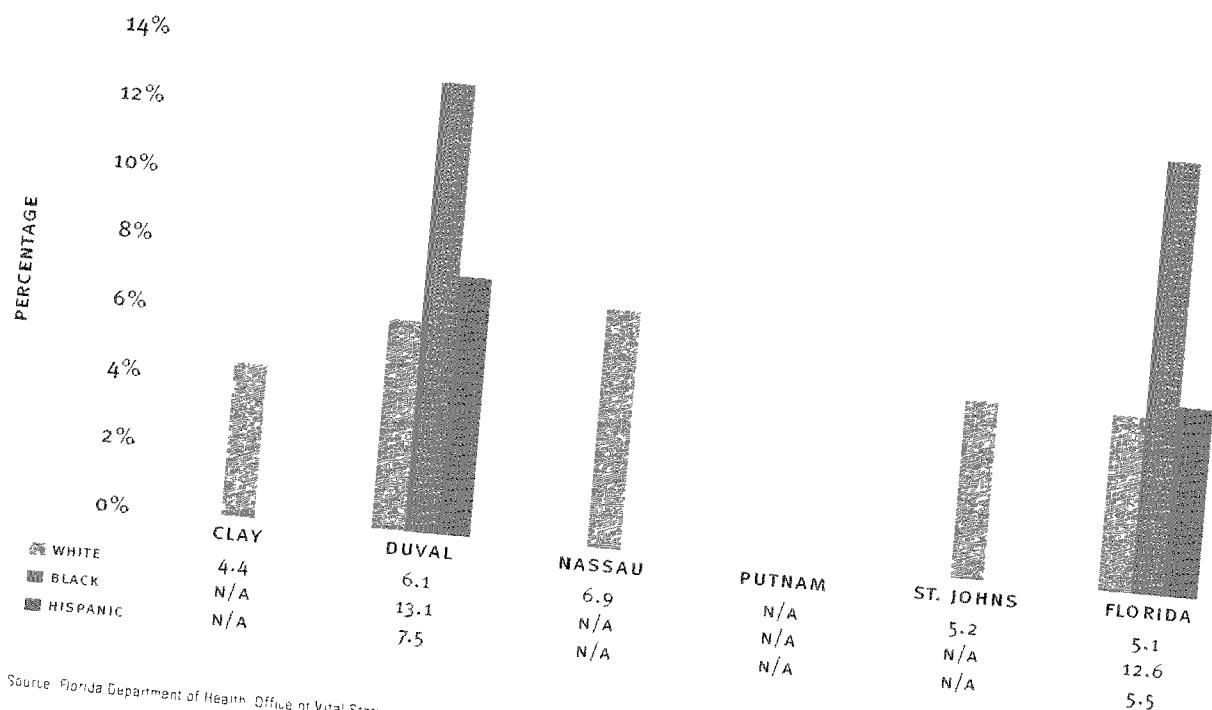


CHART 8-59 INFANT MORTALITY, BY RACE - DUVAL

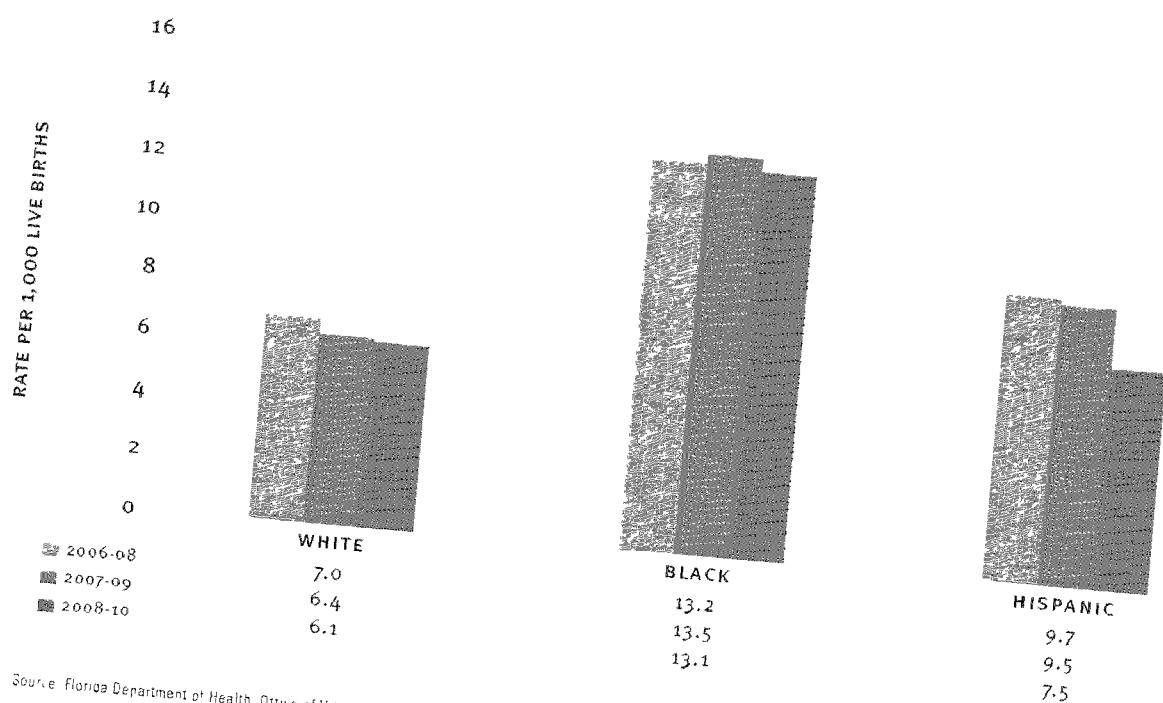
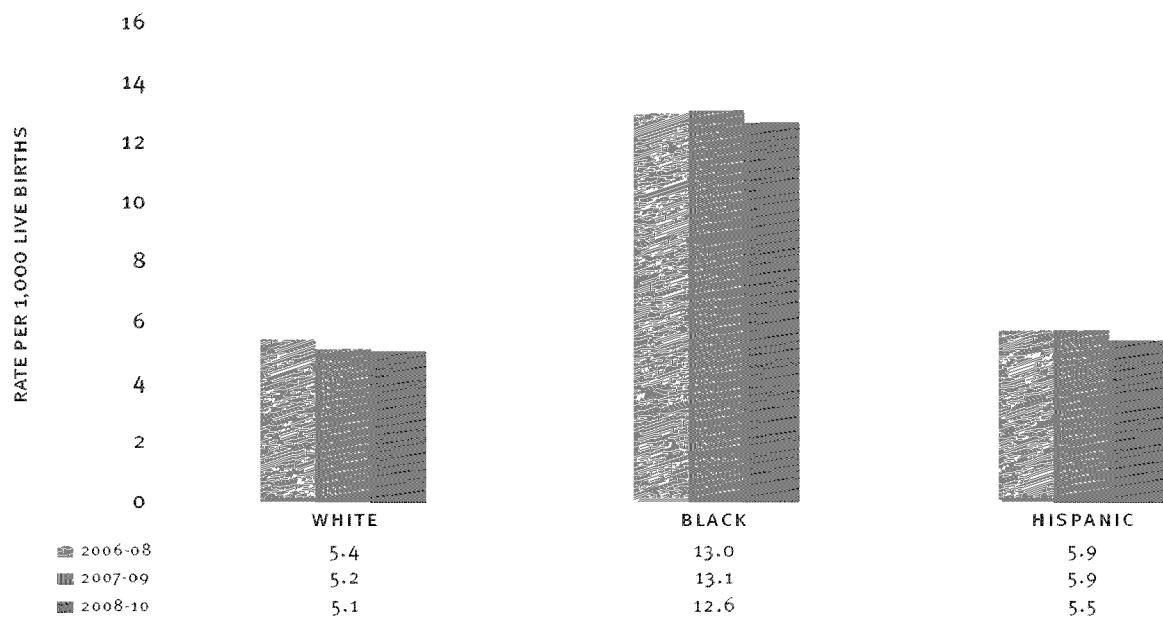
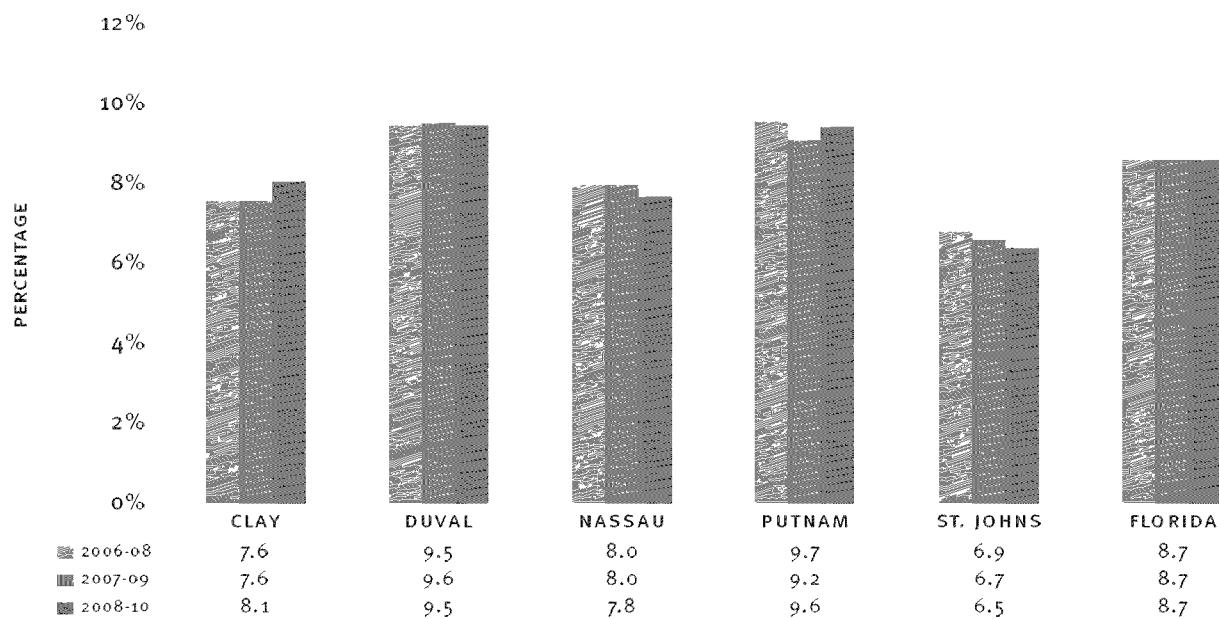


CHART 8-60 INFANT MORTALITY, BY RACE – FLORIDA



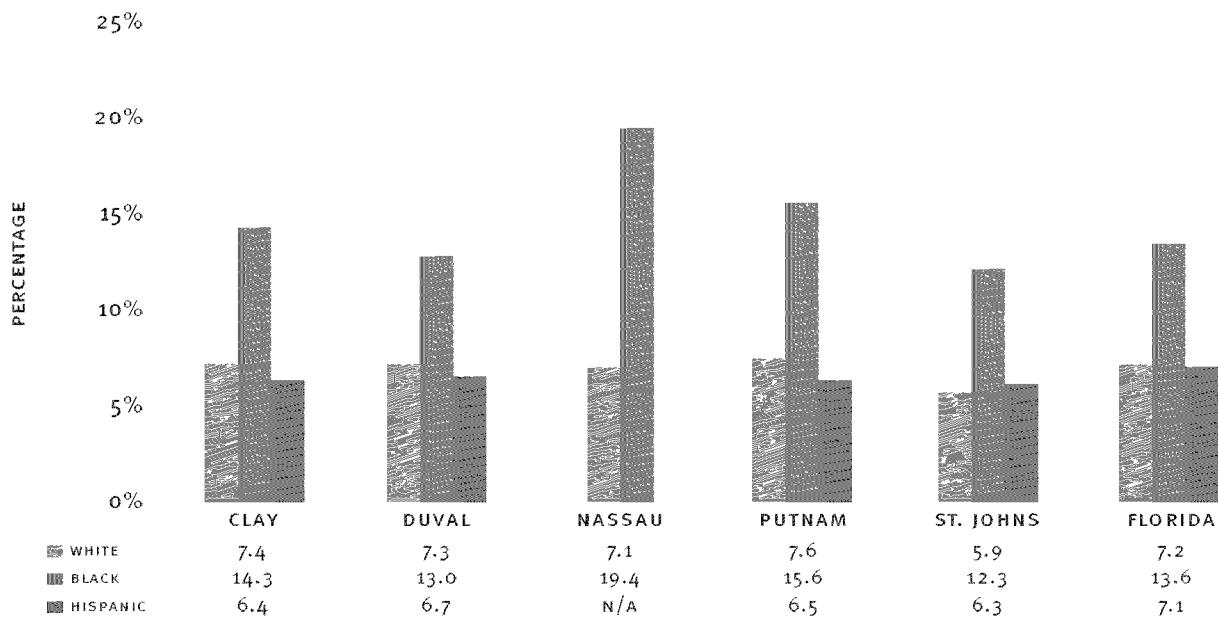
Source: Florida Department of Health Office of Vital Statistics, 2006-2010

CHART 8-61



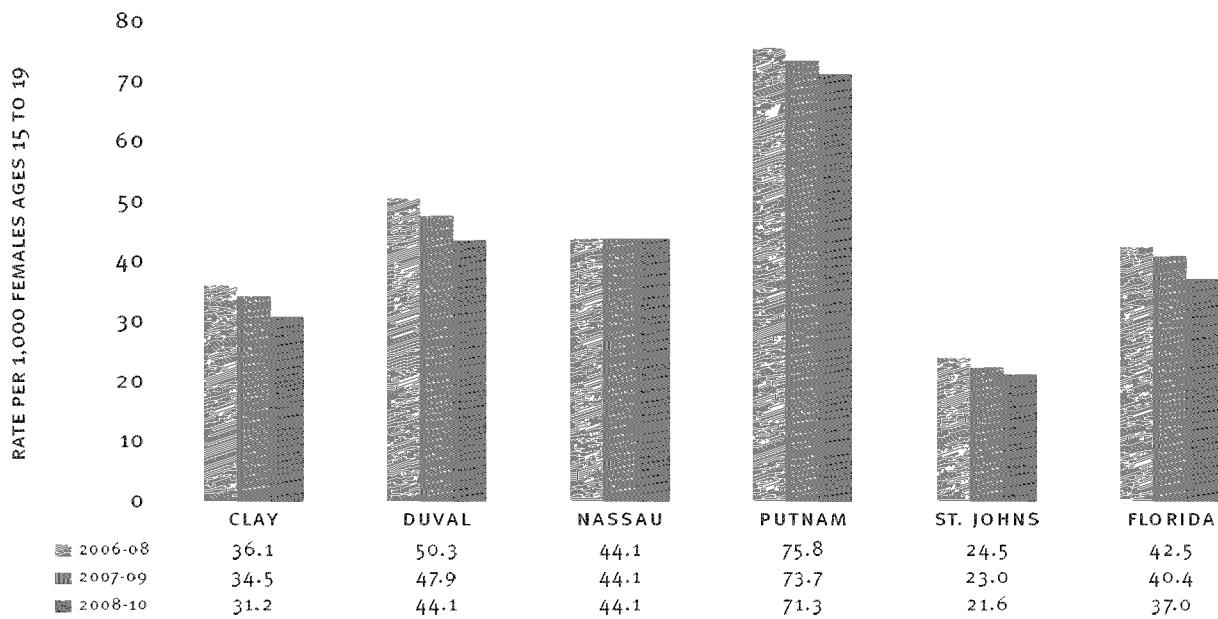
Source: Florida Department of Health Office of Vital Statistics, 2006-2010

CHART 8-62 LOW BIRTH WEIGHT (LESS THAN 2,500G), BY RACE



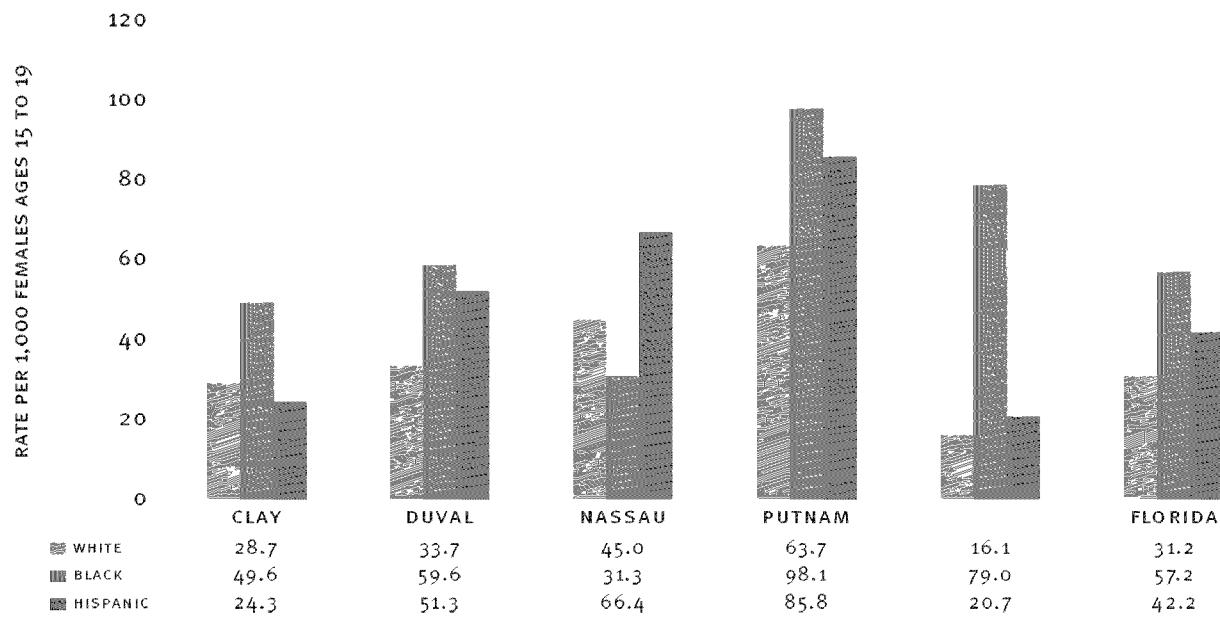
Source: Florida Department of Health, Office of Vital Statistics, 2008-2010

CHART 8-63



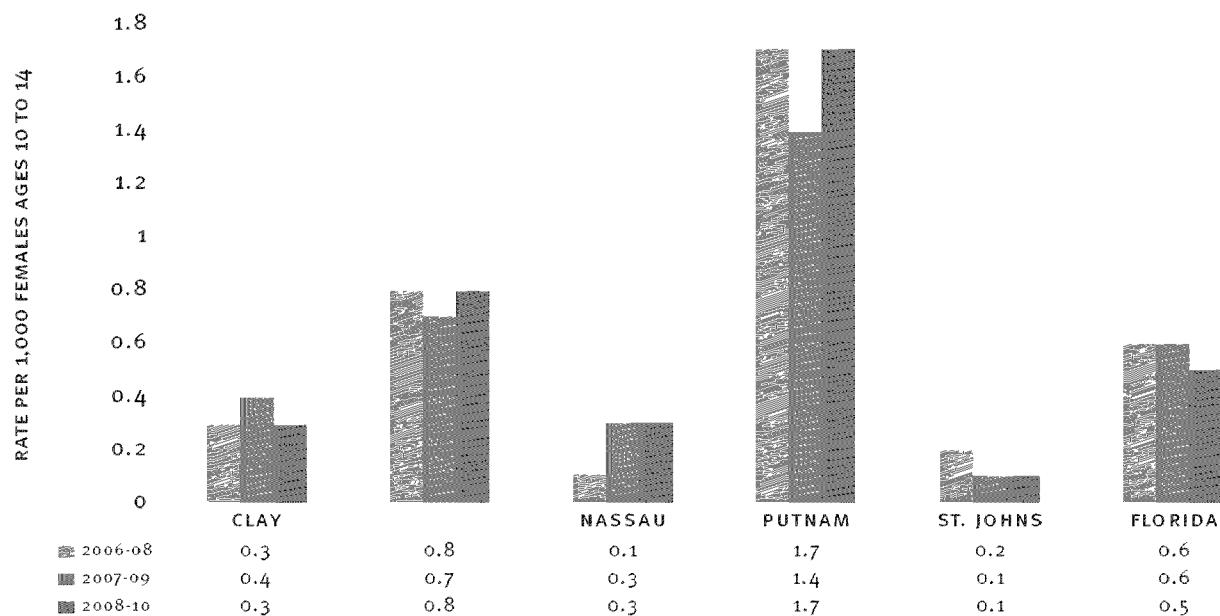
Source: Florida Department of Health, Office of Vital Statistics, 2006-2010

CHART 8-64 BIRTHS TO MOTHERS AGES 15 TO 19, BY RACE

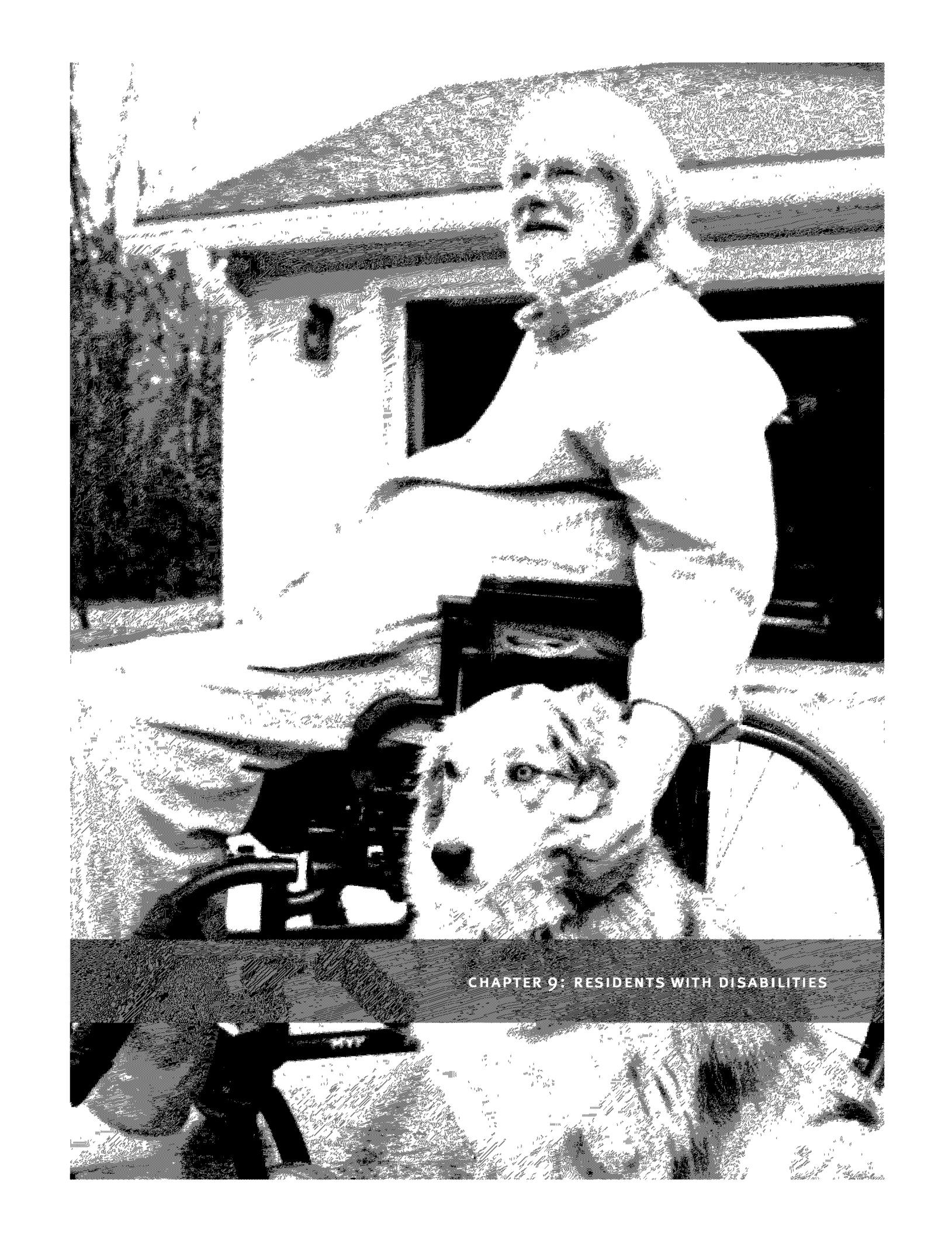


Source: Florida Department of Health, Office of Vital Statistics, 2008-2010

CHART 8-65 BIRTHS TO MOTHERS AGES 10 TO 14



Source: Florida Department of Health, Office of Vital Statistics, 2006-2010



CHAPTER 9: RESIDENTS WITH DISABILITIES

RESIDENTS WITH DISABILITIES

The *Healthy People 2020* goal to promote health and well being of people with disabilities begins in our region with an analysis of our region's disabled population. Individuals with disabilities vary greatly in their need for assistance and level of independence. The following data are from a secondary data analysis for residents with disabilities.

Adults with Disability

The percentage of adults with disabilities is the greatest in Putnam County (16.4 percent) as compared to the state percentage (12.9 percent). St. Johns County had the lowest percentage (10.9 percent), followed closely by Duval County (11.7 percent). In addition, the percentage of people with disabilities living in poverty is highest in Putnam County (26.1 percent) compared to the state (21.3 percent). Duval County is the only other county with a percentage higher than the state level (25.9 percent). See Charts 9-1 and 9-2 for more detailed information on these indicators.

The percentage of adults who use special equipment due to a health problem was highest in Putnam County (13.0 percent), followed closely by Duval County (11.3 percent), as compared to the state percentage (9.3 percent). All other counties reported less than the state percentage (see Chart 9-3).

Persons with Various Difficulties

The percentage of persons with cognitive difficulty was highest in

Only Nassau County (3.9 percent) reported a percentage lower than the state level of 4.4 percent (see Chart 9-4).

The percentage of persons with self-care difficulty was more than double the state level of 4.4 percent in both St. Johns and Duval Counties (10.4 percent and 8.7 percent, respectively). Only Nassau County (3.8 percent) reported a percentage lower than the state level (see Chart 9-5).

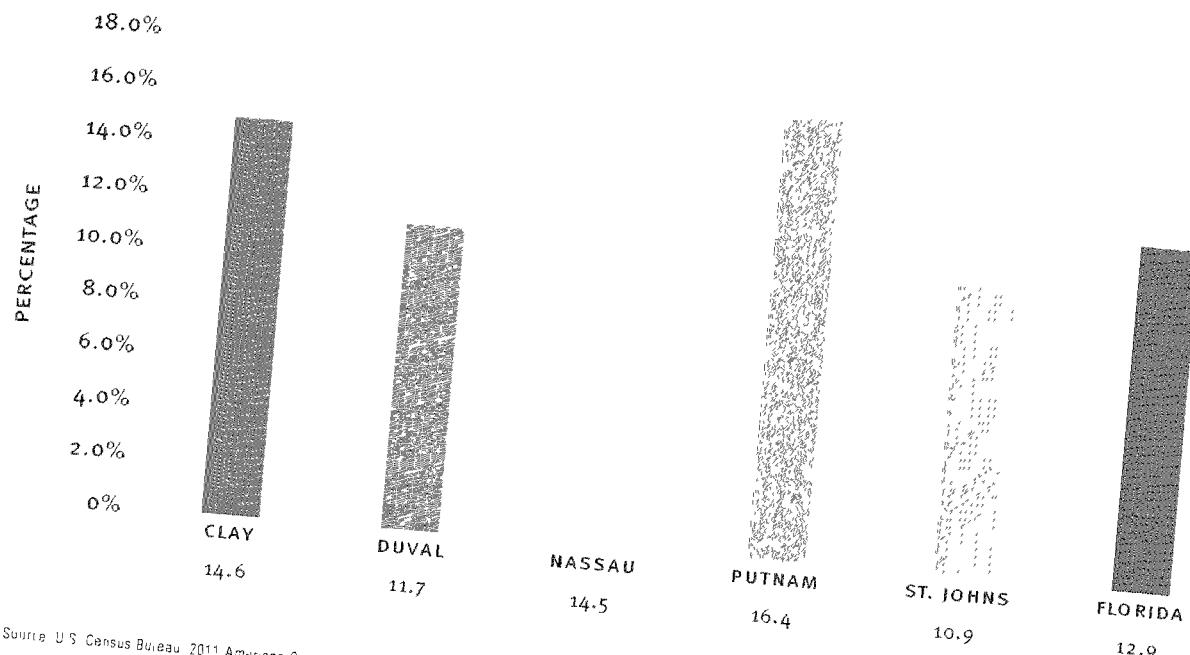
Similar to the aforementioned indicators, St. Johns and Duval Counties had the highest percentage of persons with ambulatory difficulty (10.2 percent and 8.7 percent, respectively). Nassau County (3.9 percent) reported the lowest level (see Chart 9-6).

St. Johns and Duval Counties had the highest levels for both persons with hearing difficulty and persons with vision difficulty. In both counties, the levels were at least double the state level. Keeping with the pattern, Nassau County reported the lowest levels for hearing and vision difficulties (3.5 percent and 3.4 percent, respectively) (see Charts 9-7 and 9-8).

Key Findings

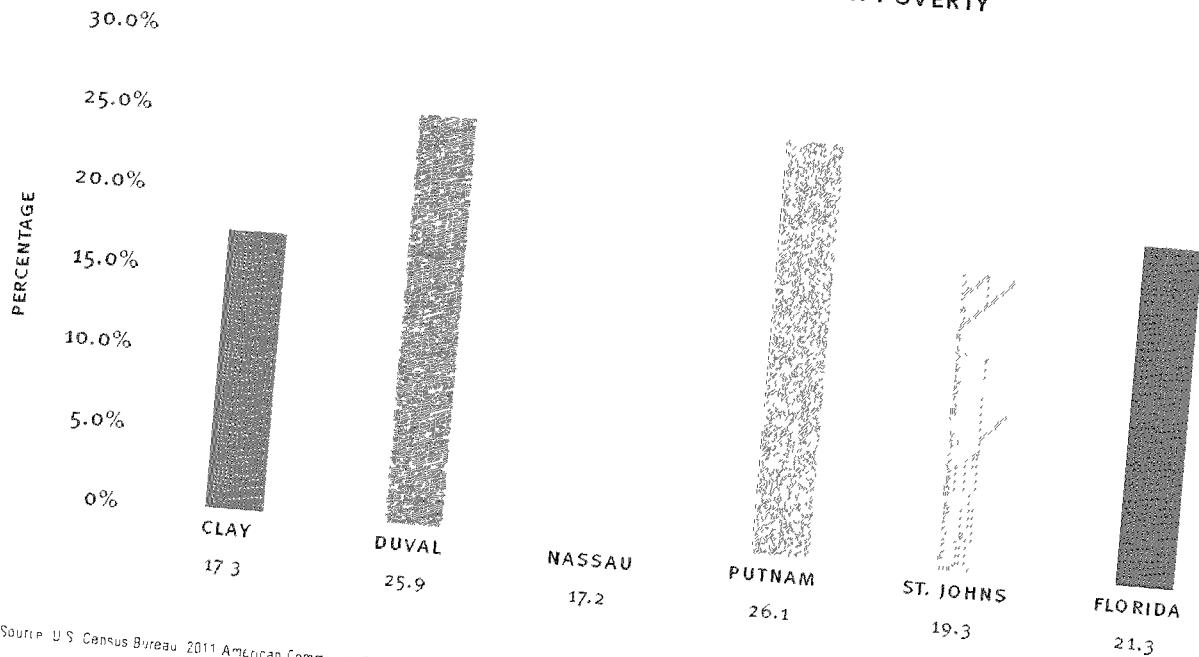
- Putnam County has the largest percentage of adults with disabilities and people with disabilities living in poverty
- Putnam County has the highest percentage of adults who use special equipment due to health problems
- St. Johns County has the highest percentages of all disability difficulty indicators (cognitive, self-care, ambulatory, hearing and vision), with levels nearly three times the state average. Duval County consistently has the second highest levels—double the state levels. (See Chart 9-9 for a comparison of all indicators across counties.)

CHART 9-1 PERCENTAGE OF POPULATION WITH DISABILITY



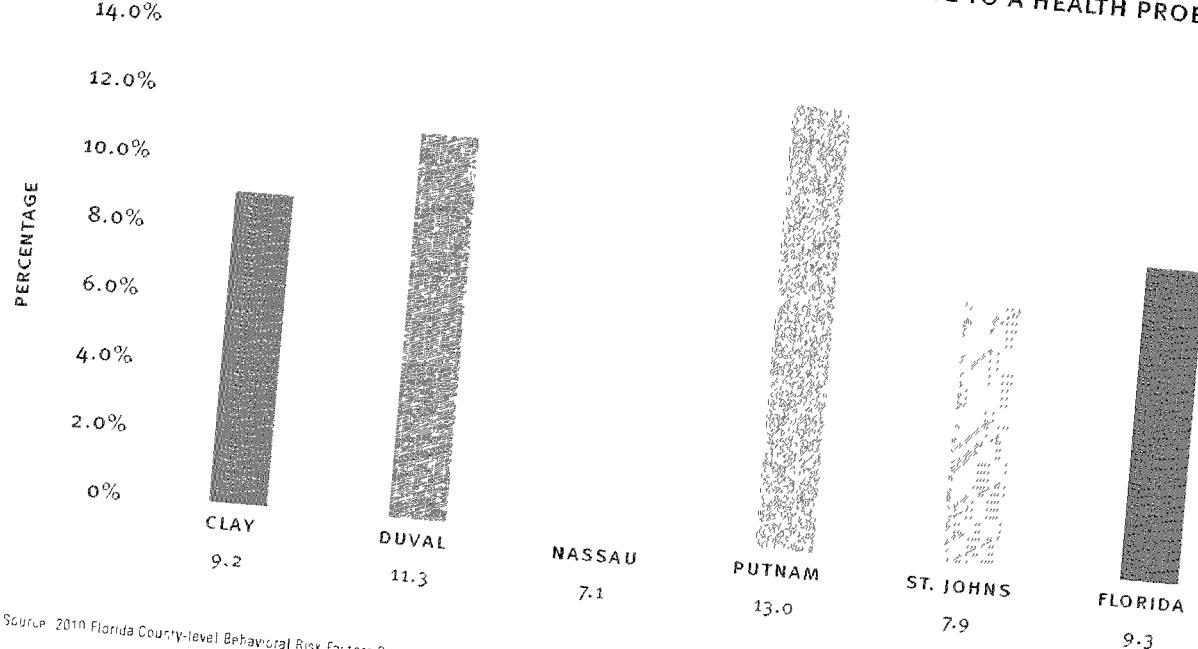
Source: U.S. Census Bureau 2011 American Community Survey

CHART 9-2 PERCENTAGE OF PEOPLE WITH DISABILITY LIVING IN POVERTY



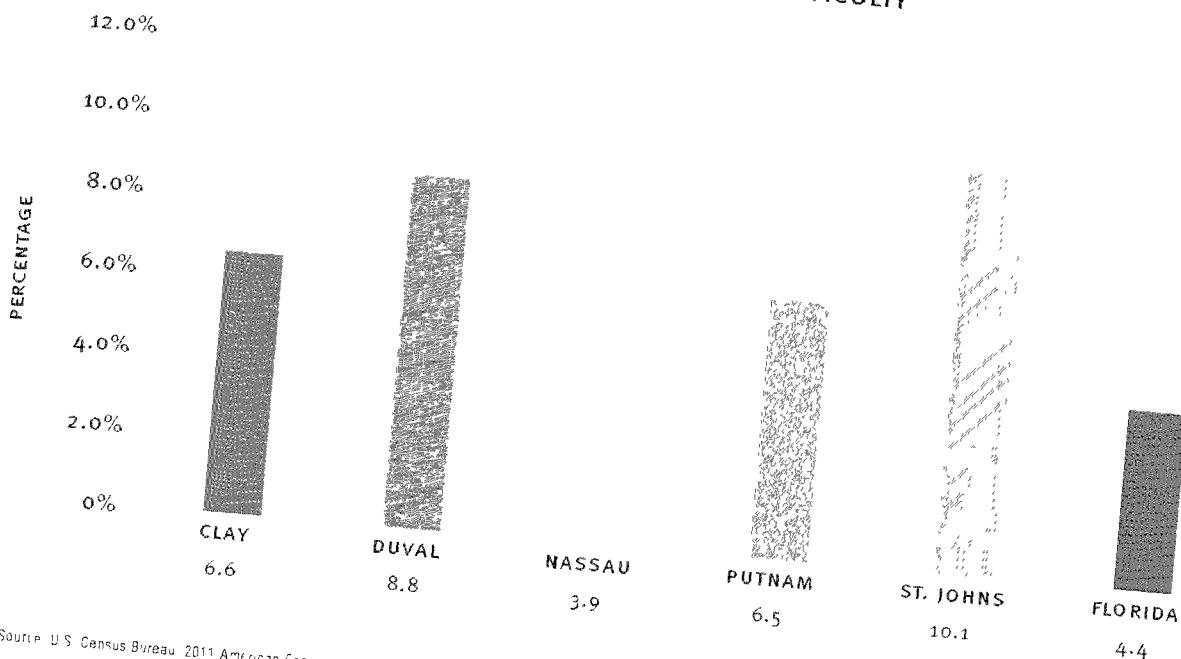
Source: U.S. Census Bureau 2011 American Community Survey

CHART 9-3 PERCENTAGE OF ADULTS WHO USE SPECIAL EQUIPMENT DUE TO A HEALTH PROBLEM



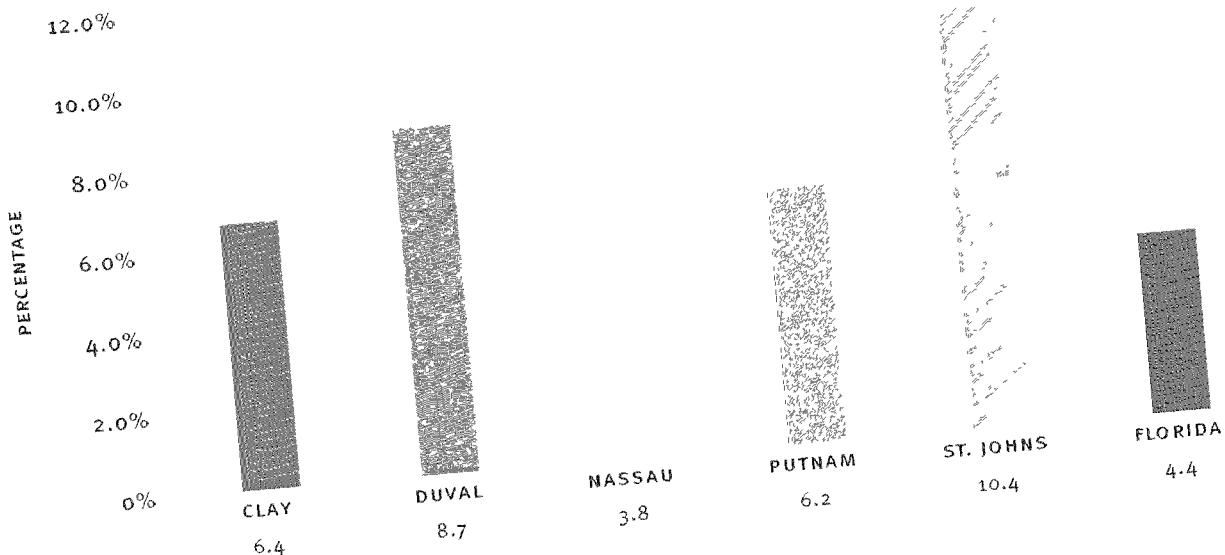
Source: 2010 Florida County-level Behavioral Risk Factors Surveillance Telephone Survey conducted by the Florida Department of Health Bureau of Epidemiology

CHART 9-4 PERCENTAGE OF PERSONS WITH COGNITIVE DIFFICULTY



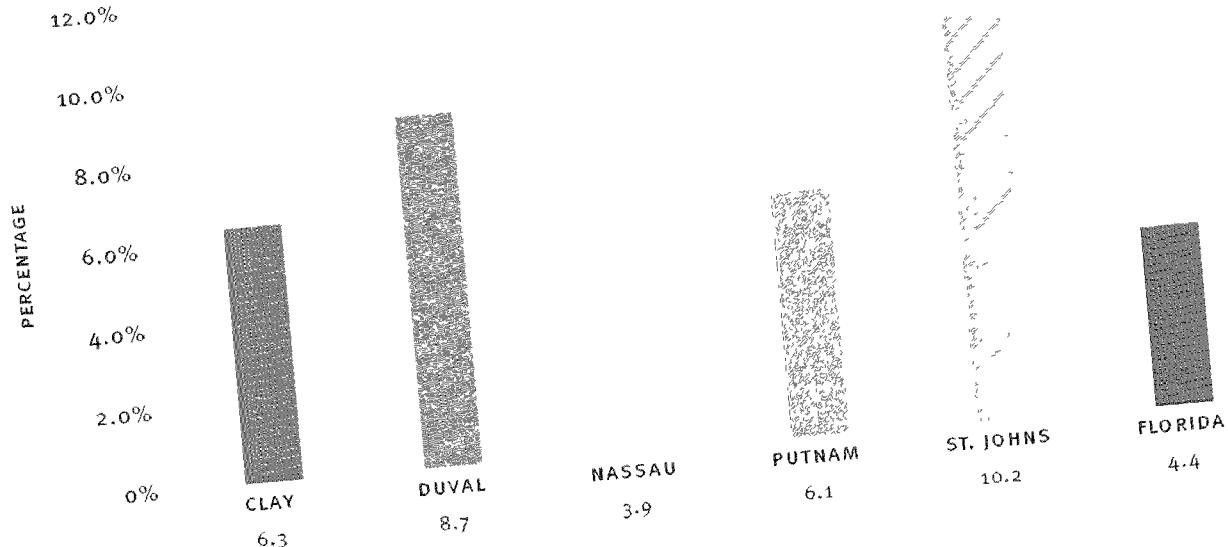
Source: U.S. Census Bureau, 2011 American Community Survey

CHART 9-5 PERCENTAGE OF PERSONS WITH SELF-CARE DIFFICULTY



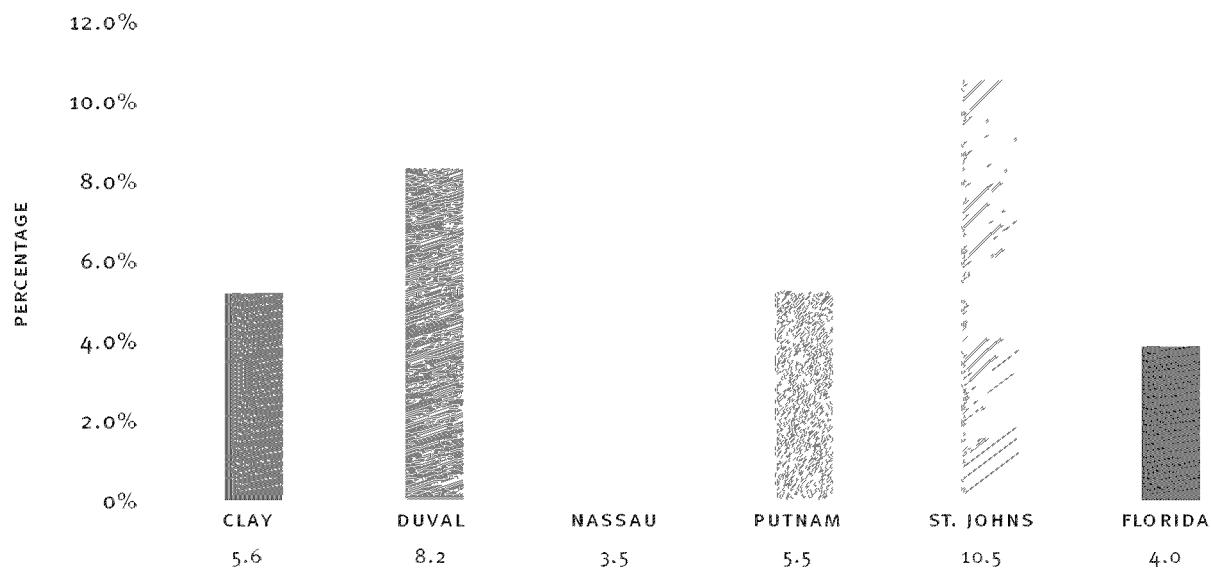
Source: U.S. Census Bureau 2011 American Community Survey

CHART 9-6 PERCENTAGE OF PERSONS WITH AMBULATORY DIFFICULTY



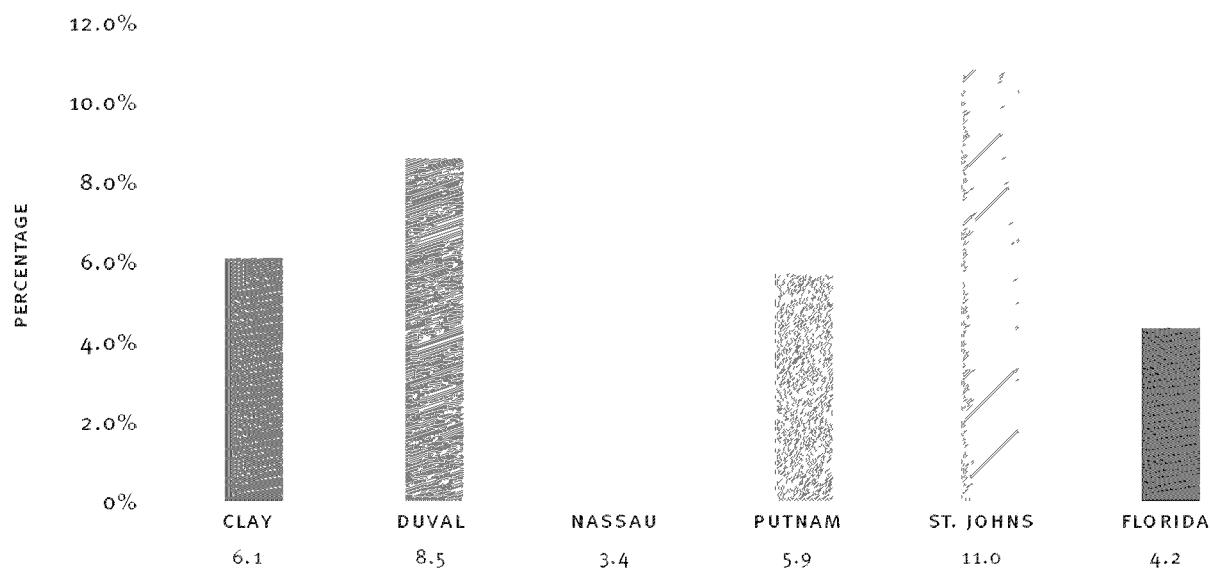
Source: U.S. Census Bureau 2011 American Community Survey

CHART 9-7 PERCENTAGE OF PERSONS WITH HEARING DIFFICULTY



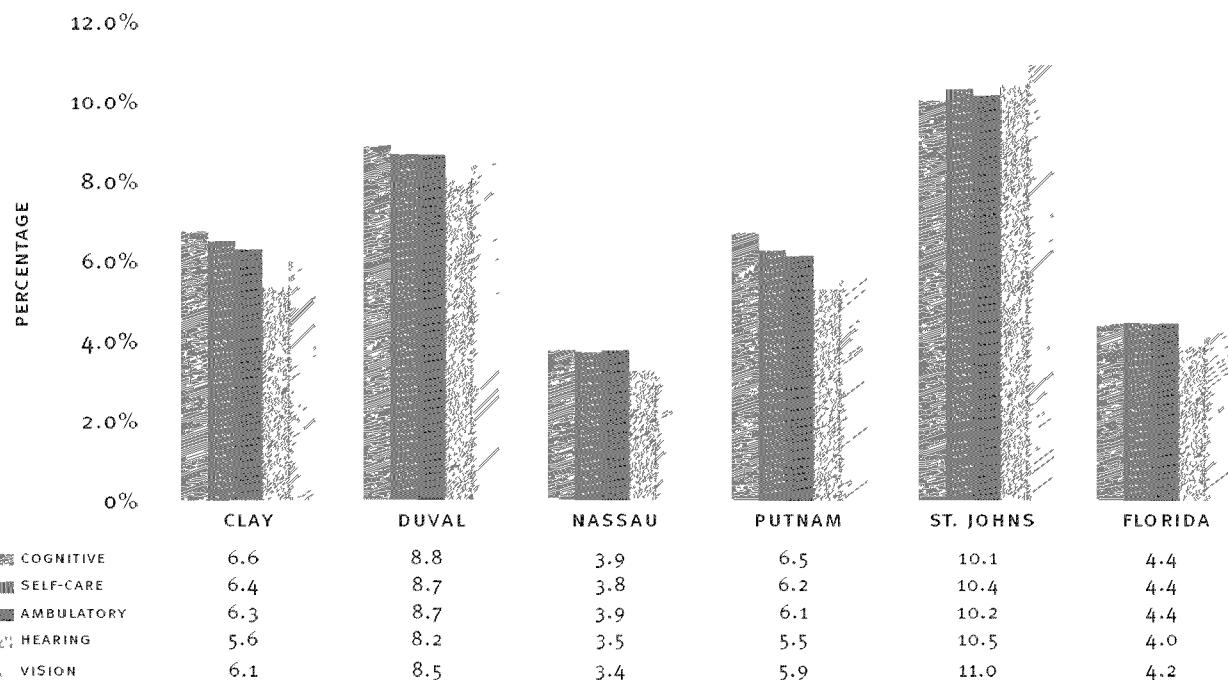
Source: U.S. Census Bureau 2011 American Community Survey

CHART 9-8 PERCENTAGE OF PERSONS WITH VISION DIFFICULTY



Source: U.S. Census Bureau 2011 American Community Survey

CHART 9-9 PERCENTAGE OF PERSONS WITH VARIOUS DIFFICULTIES



Source: U.S. Census Bureau 2011 American Community Survey



CHAPTER 10: NEEDS ASSESSMENT SUMMARIES BY COUNTY

CLAY COUNTY

CLAY COUNTY SELECTED STATISTICS*

* ADDITIONAL COUNTY INFORMATION IN RELATIONSHIP TO OTHER COUNTIES CAN BE FOUND THROUGHOUT THE COMMUNITY HEALTH NEEDS ASSESSMENT REPORT

CLAY COUNTY HEALTH RANKINGS

HEALTH OUTCOMES	#6
HEALTH FACTORS	#18

MEASURE	COUNTY	FLORIDA
POPULATION OVERVIEW		
TOTAL POPULATION	191,900	--
RACE		
WHITE	81.8%	--
BLACK	9.9%	--
ASIAN	2.9%	--
2+ RACES	2.9%	--
OTHER	1.9%	--
ETHNICITY		
HISPANIC	7.7%	--
MEDIAN HOUSEHOLD INCOME	\$58,263	\$44,409
UNEMPLOYMENT RATE (2010)	10.5%	11.5%
PUBLIC SAFETY		
FORCIBLE SEXUAL OFFENSES (PER 100,000)	60.3	52.6
HOMICIDE (PER 100,000)	5.0	6.7
LEADING CAUSES OF DEATH (AGE-ADJUSTED RATE)		
CANCER	184.7	--
HEART DISEASE	146.0	--
CHRONIC LOWER RESPIRATORY DISEASE	54.0	--
ACCESS TO FOOD		
SNAP-AUTHORIZED STORES (PER 1,000 POPULATION)	0.60	--
WIC-AUTHORIZED STORES (PER 1,000 POPULATION)	0.12	--
FAST FOOD RESTAURANTS (PER 1,000 POPULATION)	0.62	--
FARMERS' MARKETS (PER 1,000 POPULATION)	0.01	--
HEALTH CARE ACCESS		
LICENSED PRIMARY CARE PHYSICIANS (RATE PER 100,000)		
FAMILY PRACTICE	14.5	19.7
INTERNALISTS	23.7	41.8
OB/GYN	6.5	7.9
PEDIATRICIANS	11.3	14.9
TOTAL HOSPITAL BEDS (RATE PER 100,000)	180.4	320.6
POPULATION ENROLLED IN MEDICARE	14.8%	18.0%
POPULATION ENROLLED IN MEDICAID	11.7%	15.7%
HEALTH CONDITIONS AND DISEASES		
DIABETES - DEATHS (RATE PER 100,000)	30.5	19.3
OVERWEIGHT HIGH SCHOOL STUDENTS	12.10%	11.50%
BEHAVIORAL HEALTH AND SUBSTANCE USE		
SUICIDE (RATE PER 100,000)	18.3	13.9
ADULT PSYCHIATRIC BEDS (RATE PER 100,000)	20.9	18.4
CHILD/ADOLESCENT PSYCHIATRIC BEDS (RATE PER 100,000)	0.0	3.0
HIGH SCHOOL STUDENT CIGARETTE USE	19.40%	13.10%

CLAY COUNTY (CONTINUED)**HEALTH DISPARITIES**

Health insurance coverage varied greatly across demographic groups. For example, nearly a quarter of Clay County residents between the ages of 18 to 44 are uninsured, while nearly all residents ages 65 and older are insured. Non-Hispanic Black residents have a higher percentage of insured individuals than non-Hispanic White residents. Additionally, as income and education levels increase, so do levels of insured individuals.

Cancer rates in Clay County are much higher for White residents than for their Black counterparts. Hypertension rates are higher for White residents, as well as for males. However, the stroke rate is much higher among Black individuals than White individuals. Across gender, a higher percentage of females have ever had a stroke. Asthma in adults is almost identical between Black and White residents. The diabetes death rate for Black individuals is more than double that of White residents. However, the percentage of White individuals with diagnosed diabetes is higher than for Black individuals. This may be a sign of disparities in disease management. The same pattern is seen in hypertension rates. Males are also far more likely to have diabetes than women.

Overweight and obese adults are more often Black than White.

Generally, access to dental care declines as income declines. Whites demonstrated high percentages of dental care and dental visits, while Blacks had higher percentages of tooth removal due to tooth decay and gum disease.

A higher percentage of Black individuals reported good behavioral health than White individuals. In Clay County, the percentage of female tobacco smokers is slightly higher than that of males.

Hispanic residents are least likely to receive first trimester prenatal care. Black mothers have the highest percentage of births with late or no prenatal care, as well as the highest percentage of low birth weight babies. Clay County did not have minority data for infant mortality. Teenage mothers (ages 15 to 19) are most frequently Black.

PREVENTIVE HEALTH CARE

In 2010, unintentional injuries in Clay County were lower than the state rate, as was the death rate from unintentional drowning. Motor vehicle crashes have declined since 2008, and in 2010 were less than the Florida rate. While the numbers for these indicators are relatively low, unintentional injuries are the fourth leading cause of death in Clay County, accounting for nearly five percent of total deaths — more than stroke and diabetes.

Clay County has seen a recent increase in the rate of total licensed physicians, but the level is much lower than the state level. In Clay County, 86.5 percent of residents have some type of health insurance. This is higher than both the state and national average. Since 2006, the median monthly Medicaid enrollment rate has increased. The same pattern is seen in KidCare enrollment.

During 2010 through 2011, the rate of licensed dentists (per 100,000 population) was much lower than the state. While the percentage of low-income persons with access to dental care is considered low, the percentage of low-income residents accessing dental services is above the percentage for the state of Florida. Survey respondents indicated that dental care is the third most frequently delayed service (behind "visit to doctor" and "medical test, exam or screening"). While the number of dentists does play a part in the accessibility of dental care, focus group participants feel that insurance coverage dictates which health services are accessible to each person, especially dentists. Focus group participants did not mention difficulty in receiving hearing or vision services. However, the most commonly delayed tests or exams among survey respondents were eye exams (44 percent).

CLAY COUNTY (CONTINUED)

Affordability (a barrier to care) plays a role in the decisions for residents to take care of their health. Of those survey respondents who stated that they had delayed health care services, the three most frequently noted reasons for delaying health care treatment were "inability to pay" (38 percent), "no insurance" (35 percent) and "concerned about spending in current economy" (33 percent).

For some, physical barriers (i.e., disability, injury) or behavioral health difficulties make physical activity challenging. This is the case for more than 20 percent of Clay County residents. Within the past 12 months approximately 56 percent of Clay County respondents reported that they had delayed eye care visits. Rates in 2010 for immunization levels in kindergarten-aged children were, on average, higher than the state rate of 91.3 percent for Clay County. Percentages of adults age 65 years and older who have ever received a pneumonia vaccination were comparatively lower than the state rate of 69.9 percent.

Suicide rates have increased since 2006.

The highest percentage of high school-age smokers is in Clay County (19.4 percent). The level of overweight people in Clay County is above the state level, as is the level of overweight high school students.

In the overall Community Health Needs Assessment region, the types of tests or exams most frequently delayed were eye exams, pap smears and mammograms.

BUILT ENVIRONMENT

Residents in Clay County have limited access to local food sources (e.g., farmers' markets). Fast food restaurants are far more available.

Only eight percent of the water system population has fluoridated water. While Clay County received a four (out of five) on the Natural Amenities Scale, it had the lowest rating of the five counties. No air quality data was reported for Clay County. Levels of asthma indicators (hospitalization and diagnosis rates) were at or better than the state levels.

Eighty-three percent of Clay County high school students graduate.

The domestic violence rate is well below the Florida average. Levels of homicide and aggravated assault are also below the state level. However, Clay County has a forcible sex offense rate that is higher than the state level.

DISABILITY

In Clay County, 32.6 percent of residents ages 65 and older have a disability; this is lower than the state average of 34.2 percent. The percentage of people with disabilities living in poverty is 20.1 percent, slightly less than the state level (20.7 percent). Approximately nine percent (9.2 percent) of adults use special equipment due to a health problem, which is about the same as the Florida average of 9.3 percent.

The percentage of persons with cognitive difficulty is 5.9 percent, higher than the state level of 4.8 percent. The rate of persons with self-care difficulty (2.0 percent) is slightly lower than the state average of 2.6 percent. The rate of individuals with ambulatory difficulty is 7.1 percent, nearly the same as the Florida average of 6.9 percent.

DUVAL COUNTY

DUVAL COUNTY SELECTED STATISTICS

* ADDITIONAL COUNTY INFORMATION IN RELATIONSHIP TO OTHER COUNTIES CAN BE FOUND THROUGHOUT THE COMMUNITY HEALTH NEEDS ASSESSMENT REPORT

COUNTY HEALTH RANKINGS

HEALTH OUTCOMES	#44
HEALTH FACTORS	#32

MEASURE	COUNTY	FLORIDA
POPULATION OVERVIEW		
TOTAL POPULATION	892,400	--
RACE		
WHITE	60.9%	--
BLACK	29.5%	--
ASIAN	4.2%	--
2+ RACES	2.9%	--
OTHER	2.1%	--
ETHNICITY		
HISPANIC	7.6%	--
MEDIAN HOUSEHOLD INCOME	\$46,078	\$44,409
UNEMPLOYMENT RATE (2010)	11.7%	11.5%
SCHOOL AND STUDENT POPULATION		
GRADUATION RATE	71.2%	80.1%
GANG ACTIVITY		
FIGHTING	59.6%	45.8%
THEFT	37.5%	28.5%
VANDALISM	38.1%	30.4%
DRUG SALES	43.9%	34.1%
CARRYING WEAPONS	32.4%	19.5%
PUBLIC SAFETY		
DOMESTIC VIOLENCE OFFENSES (PER 100,000)	1,056.9	603.4
FORCIBLE SEX OFFENSES (PER 100,000)	78.3	52.6
HOMICIDE (PER 100,000)	12.2	6.7
LEADING CAUSES OF DEATH (AGE-ADJUSTED RATE)		
CANCER	180.2	--
HEART DISEASE	170.3	--
CHRONIC LOWER RESPIRATORY DISEASE	50.4	--
BUILT ENVIRONMENT		
AIR QUALITY		
OZONE	0.7 (B GRADE)	
PARTICLE POLLUTION	0.3 (B GRADE)	
PERCENTAGE OF WATER SYSTEM FLUORIDATED	99.2%	
ACCESS TO FOOD		
SNAP-AUTHORIZED STORES (PER 1,000 POPULATION)	1.11	
WIC-AUTHORIZED STORES (PER 1,000 POPULATION)	0.12	
FAST FOOD RESTAURANTS (PER 1,000 POPULATION)	0.83	
FARMERS' MARKETS (PER 1,000 POPULATION)	0.01	
HEALTH CARE ACCESS		
TOTAL LICENSED PHYSICIANS (RATE PER 100,000)	285.6	--
TOTAL HOSPITAL BEDS (RATE PER 100,000)	399.6	320.6
REHABILITATION BEDS (RATE PER 100,000)	17.4	12.4
POPULATION ENROLLED IN MEDICARE	13.0%	18.0%
POPULATION ENROLLED IN MEDICAID	17.0%	15.7%

DUVAL COUNTY (CONTINUED)

HEALTH CONDITIONS AND DISEASES		
ASTHMA HOSPITALIZATIONS (RATE PER 100,000)		
AGES 5 TO 11	275.1	411.9
AGES 12 TO 18	230.2	330.9
DIABETES DEATHS (RATE PER 100,000)	26.6	19.3
BEHAVIORAL HEALTH AND SUBSTANCE USE		
ADULT SUBSTANCE ABUSE BEDS (RATE PER 100,000)	5.1	2.1
SEXUALLY TRANSMITTED DISEASES		
GONORRHEA (RATE PER 100,000)	247	114
CHLAMYDIA (RATE PER 100,000)	674.6	388.8
NEW HIV CASES (RATE PER 100,000)	41.4	31.8
NEW AIDS CASES (RATE PER 100,000)	30.3	22.3
INFECTION DISEASES		
TUBERCULOSIS (RATE PER 100,000)	10.2	4.6

LOW-INCOME – ATLANTIC BEACH

LOW-INCOME – BALDWIN

LOW-INCOME – EAST JACKSONVILLE

LOW-INCOME – SOUTH JACKSONVILLE

LOW-INCOME – WEST JACKSONVILLE

HEALTH DISPARITIES

Overall, 82.7 percent of Duval County residents have health insurance of some type. The 18- to 44-year-old age group had the lowest percentage of insured individuals, while nearly all residents ages 65 and older were insured. While White individuals have a higher insured percentage, the gap between them and Black residents is smaller than in other counties and the state as a whole. The differences across education level are similar, with those with a higher education having a slightly higher percentage of insured individuals. Income appears to make a large difference.

When it comes to accessing health care services, affordability and time constraints were two common barriers mentioned in the focus groups.

When asked about the quality of the health care services in their area, Duval County residents were least satisfied and gave the highest percentage of “poor” ratings. Additionally, Duval County has the highest rate of licensed physicians, pediatricians, OB/GYNs, internists and family practitioners.

In Duval County, Black and White individuals have similar rates of cancer, and the Hispanic rate is less than half of that. Duval County has the highest rate of hypertension for Black residents. Strokes are far more common among Black individuals and women. The percentage of adults with diagnosed diabetes between Black and White residents is nearly identical. However, the death rate for diabetes is much higher for Black individuals. This could signal a disparity in disease management and treatment. White adults have a higher percentage of individuals with asthma.

DUVAL COUNTY (CONTINUED)

Duval County has the highest number of homeless individuals. The homeless are more often Black, male and between the ages of 18 to 60.

PREVENTIVE HEALTH CARE

Black residents reported good behavioral health more often than their White counterparts. Duval County is the only county that provides child and adolescent psychiatric beds, and they do so at a rate similar to that of the state.

Smoking percentages for males are higher than for females in Duval County. Nearly 19 percent of Duval County residents smoke tobacco, including 3.5 percent of middle school students and 13.2 percent of high school students; 4.5 percent of high school students use smokeless tobacco. Binge drinking among adults is slightly higher than the state level.

The rate of obesity in Duval County is 28.4 percent, this is higher than the state rate of 27.2 percent. The percentage of overweight and obese adults is higher for Black residents than White residents.

Births with late or no prenatal care were the highest in Duval County. Duval County had the highest infant mortality rate for 2010 (8.8 per 1,000 live births) as compared to the state (6.9 per 1,000 live births). The rate of low birth weight (less than 2,500g) babies was the highest in Duval County. The largest group of births with late or no prenatal care came from Black women. Infant mortality and low birth weight were also highest among this group. The largest group of teenage mothers (ages 15 to 19) came from the Black community.

The unintentional injury rate in Duval County is lower than the state level, while the unintentional drowning rate is almost exactly the same. The motor vehicle crash rate is just below the state rate.

Duval County sees the highest number of patients on all traumatic brain injury indicators. However, because rates are measured in number of patients and Duval County has the largest population, this is to be expected.

The percentage of adults who visited a dentist or dental clinic in the past year only differed by 1.5 percent across race. However, Black residents were far more likely to have a permanent tooth removed because of tooth decay or gum disease. White residents were more likely to have had their teeth cleaned in the past year.

Survey respondents indicated that dental care is the third most frequently delayed service (behind "visit to doctor" and "medical test, exam or screening"). All five counties in the assessment region are below the state average for rate of total licensed dentists. While the number of dentists does play a part in the accessibility of dental care, focus group participants feel that insurance coverage dictates which health services are accessible to each person, especially dentists. Access to dental care by low-income persons has increased in Duval County since 2008. Duval County has the largest number of vision practitioners and audiologists. However, because these indicators are measured in numbers and Duval County has the largest population, this is expected. Within the past 12 months, approximately 21 percent of Duval County respondents reported that they had delayed eye care visits.

Duval County marked the highest rate of childhood immunization. Duval County demonstrated the lowest percentage of adults age 65 and older who have ever received a pneumonia vaccination.

The Duval County rate for infectious syphilis has been higher than the state level since 2008, and has been increasing. Duval County is the only county in the assessment region that has new HIV/AIDS case rates higher than the state of Florida. The tuberculosis level in Duval County is more than double that of the state.

DUVAL COUNTY (CONTINUED)

BUILT ENVIRONMENT

Duval County's aggravated assault rates are consistently above the state average. Duval County is the only county in the assessment region to see an increase in forcible sex offenses, and had the highest rate in 2010 at 78.3 per 100,000. Duval County has the highest homicide rate in the assessment region at 12.2 per 100,000. Focus group participants feel safe in most areas of Duval County, but acknowledge that there are some high-crime pockets that do not feel safe. Many participants expressed concern about safety and security at public schools. Fighting is the most common juvenile crime behavior.

Only in Duval County are there more Black students than White. The Duval County high school graduation rate is below the state level. However, Duval County has the lowest rate of school absence at 5.9 percent.

Duval County received a score of four out of five on the Natural Amenities Scale. On both measures of air quality (ozone and particle pollution), the county was given a grade of "B." Even still, the percentages of students (middle and high school), as well as adults, with asthma are all above the state average.

Nearly all of the water system population receives fluoridated water.

Duval County has more fast food restaurants than either full-service restaurants or farmers' markets. Convenience stores make up close to half of the available stores. More than 40 percent of Duval County students were eligible for free lunch in 2009. Access to food greater than one mile away is difficult, when the food is more than 10 miles away, it is nearly impossible. There are numerous pockets of Duval County that qualify as food deserts. Most of them are in the urban core of Jacksonville.

Residents of Duval County placed the most importance on access to public transportation (51 percent responded "very important"). Additionally, African-American respondents gave access to public transportation the most "very important" answers (75 percent). As might be expected, the importance placed on access to public transportation decreases overall with rise in income. The importance is highest for those making less than \$15,000 (96 percent) and lowest for those making \$100,000 or more (70 percent).

DISABILITY

In Duval County, 35.7 percent of residents ages 65 and older have a disability, this is higher than the state average of 34.2 percent. The percentage of people with disabilities living in poverty is 22.0 percent, slightly more than the state level (20.7 percent). The rate of _____ who use special equipment due to a health problem is 11.3 percent, higher than the Florida average of 9.3 percent.

NASSAU COUNTY

NASSAU COUNTY SELECTED STATISTICS

* ADDITIONAL COUNTY INFORMATION IN RELATIONSHIP TO OTHER COUNTIES CAN BE FOUND THROUGHOUT THE COMMUNITY HEALTH NEEDS ASSESSMENT REPORT

COUNTY HEALTH RANKINGS

HEALTH OUTCOMES	#27
HEALTH FACTORS	#17

MEASURE	COUNTY	FLORIDA
POPULATION OVERVIEW		
TOTAL POPULATION	73,600	--
RACE		
WHITE	89.8%	--
BLACK	6.4%	--
ASIAN	0.9%	--
2+ RACES	1.6%	--
OTHER	0.9%	--
ETHNICITY		
HISPANIC	3.2%	--
MEDIAN HOUSEHOLD INCOME	\$60,729	\$44,409
UNEMPLOYMENT RATE (2010)	10.9%	11.5%
SCHOOL AND STUDENT POPULATION		
GRADUATION RATE	93.8%	80.1%
GANG ACTIVITY		
FIGHTING	12.6%	45.8%
THEFT	11.0%	28.5%
VANDALISM	10.7%	30.4%
DRUG SALES	17.2%	34.1%
CARRYING WEAPONS	17.0%	19.5%
PUBLIC SAFETY		
UNINTENTIONAL INJURY (PER 100,000)	54	41.3
LEADING CAUSES OF DEATH (AGE ADJUSTED RATES)		
CANCER	155.4	--
HEART DISEASE	159.2	--
CHRONIC LOWER RESPIRATORY DISEASE	48.9	--
ACCESS TO FOOD		
SNAP-AUTHORIZED STORES (PER 1,000 POPULATION)	0.81	
WIC-AUTHORIZED STORES (PER 1,000 POPULATION)	0.13	
FAST FOOD RESTAURANTS (PER 1,000 POPULATION)	0.42	
FARMERS' MARKETS (PER 1,000 POPULATION)	0.02	
HEALTH CARE ACCESS		
LICENSED PRIMARY CARE PHYSICIANS (RATE PER 100,000)		
FAMILY PRACTICE	20.3	19.7
INTERNALISTS	9.5	41.8
OB/GYN	4.1	7.9
PEDIATRICIANS	5.4	14.9
TOTAL HOSPITAL BEDS (RATE PER 100,000)	73.7	320.6
TOTAL SPECIALTY BEDS (RATE PER 100,000)	0.0	55.4
POPULATION ENROLLED IN MEDICARE	18.5%	18.0%
POPULATION ENROLLED IN MEDICAID	12.1%	15.7%
TOTAL LICENSED DENTISTS (RATE PER 100,000)	26.9	62.7
HEALTH CONDITIONS AND DISEASES		
DIABETES DEATHS (RATE PER 100,000)	26.6	19.3
DIABETES HOSPITALIZATIONS IN CHILDREN - AGES 5 TO 11 (RATE PER 100,000)	60.9	44.2

NASSAU COUNTY (CONTINUED)

HEALTH CONDITIONS AND DISEASES (CONTINUED)			
OVERWEIGHT TEENS (BMI AT OR ABOVE 95 PERCENTILE)			
MIDDLE SCHOOL	13.5	11.7	
HIGH SCHOOL	13.6	11.5	
BEHAVIORAL HEALTH AND SUBSTANCE USE			
SUICIDE (RATE PER 100,000)	21.2	13.9	
ADULT PSYCHIATRIC BEDS (RATE PER 100,000)	0.0	18.4	
CHILD/ADOLESCENT PSYCHIATRIC BEDS (RATE PER 100,000)	0.0	3.0	
HIGH SCHOOL STUDENT SMOKELESS TOBACCO USE	12.00%	6.40%	

HEALTH DISPARITIES

The percentage of the population that has health insurance varies by age. Residents ages 18 to 44 have the lowest level of insurance, while 100 percent of residents ages 65 and older are covered. Nassau County did not have insurance percentages to report for Black residents. Education and income levels both related positively to percentage of insured residents, as they increase, so does the percentage of insured individuals.

Nassau County did not report data on disparities across race for dental services. This was also true for percentages of adults with hypertension, rate of stroke, obesity and percentage of adults with asthma.

Cancer rates among Blacks are higher than those of Whites in Nassau County. A higher percentage of men have hypertension than women. The rate of coronary heart disease for Black individuals is almost triple that of White residents. The death rate from diabetes for Black residents is more than three times that of their White counterparts.

The levels of asthma in adults, middle school and high school students are lower than the state level. The same is true for the diabetes death rate.

Infant mortality has increased since 2006 and is currently higher than the state level.

The highest percentages of low birth weight babies were reported in Black residents and were significantly higher in Nassau County. White mothers were more likely to have first trimester prenatal care than Black or Hispanic mothers. Births to mothers ages 15 to 19 occurred most frequently in the Hispanic community.

PREVENTIVE HEALTH CARE

Nassau County was the only county in the Community Health Needs Assessment (CHNA) region with more White residents reporting good behavioral health than Black residents.

The unintentional injury rates in Nassau County have declined, but are still higher than the state level. The death rate from unintentional drowning has essentially been cut in half, and is now the lowest in the region. The rate of motor vehicle crashes has declined, but is still higher than the state level.

Nineteen percent of traumatic brain injury visits at Baptist Medical Center Nassau were sports-related.

Of those who had delayed health care services in the last 12 months, 73 percent had delayed a visit to a doctor or physician. The next most delayed service was medical test, exam or screening (42 percent). The third most

NASSAU COUNTY (CONTINUED)

frequently delayed service was dental care (28 percent). The types of tests or exams most frequently delayed were eye exams (44 percent), pap smears (41 percent) and mammograms (34 percent). The three most frequently noted reasons for delaying health care treatment were "inability to pay" (38 percent), "no insurance" (35 percent) and "concerned about spending in current economy" (33 percent). Nassau County has the lowest number of licensed physicians in the region. Affordability and time constraints were two common barriers mentioned in the focus groups.

Access to dental services for low-income individuals has decreased since 2008 in Nassau County. Even with the decline, Nassau levels are still much higher than the state level. Nassau County displayed a significant decrease in

The 2010 rates for immunization levels in kindergarten-aged children were, on average, higher than the state rate of 91.3 for Nassau County.

Suicide rates have increased markedly since 2006 and sit well above the state average.

Nearly 20 percent of Nassau County residents smoke tobacco. High school student use of smokeless tobacco occurs at a level that is nearly double that of the state average.

BUILT ENVIRONMENT

There

Drug sales and carrying weapons are the most frequently reported gang activity. The most dramatic decline in aggravated assault was in Nassau County. Nassau now has the lowest rate in the CHNA region. The rate of forcible sex offenses in Nassau County is well below the state average.

More than one percent of the children in Nassau County showed elevated blood lead levels. Approximately three-quarters of the water system population receive fluoridated water.

In Nassau County, there are more full-service restaurants than fast food restaurants. More than half of the stores available are convenience stores.

DISABILITY

In Nassau County, 36 percent of residents ages 65 and older have a disability, this is higher than the state average of 34.2 percent. The percentage of people with disabilities living in poverty is 19.8 percent, slightly less than the state level (20.7 percent). The percentage of adults who use special equipment due to a health problem is 7.1 percent, lower than the Florida average of 9.3 percent.

The percentage of persons with cognitive difficulty in Nassau County is 3.8 percent, less than the state level of 4.8 percent. The rate of persons with self-care difficulty (3.2 percent) is slightly higher than the state average (2.6 percent). The rate of individuals with ambulatory difficulty is 9.2 percent, higher than the Florida level of 6.9 percent.

PUTNAM COUNTY

PUTNAM COUNTY SELECTED STATISTICS

* ADDITIONAL COUNTY INFORMATION IN RELATIONSHIP TO OTHER COUNTIES CAN BE FOUND THROUGHOUT THE COMMUNITY HEALTH NEEDS ASSESSMENT REPORT.

COUNTY HEALTH RANKINGS

HEALTH OUTCOMES	#65
HEALTH FACTORS	#61

MEASURE COUNTY FLORIDA

POPULATION OVERVIEW		
TOTAL POPULATION	74,300	--

RACE		
WHITE	77.3%	--
BLACK	16.2%	--
ASIAN	0.6%	--
2+ RACES	1.7%	--
OTHER	3.6%	--

ETHNICITY		
HISPANIC	9.0%	--

MEDIAN HOUSEHOLD INCOME	\$33,842	\$44,409
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POVERTY LEVELS		
CHILDREN	35.6%	19.5%
ALL FAMILIES	24.6%	12.0%

UNEMPLOYMENT RATE (2010)	12.6%	11.5%
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SCHOOL AND STUDENT POPULATION

SCHOOL ABSENCE	17.1%	9.5%
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GANG ACTIVITY		
FIGHTING	67.6%	45.8%
THEFT	34.3%	28.5%
VANDALISM	38.3%	30.4%
DRUG SALES	51.4%	34.1%
CARRYING WEAPONS	41.1%	19.5%

PUBLIC SAFETY

UNINTENTIONAL INJURY (RATE PER 100,000)	86.9	41.3
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UNINTENTIONAL DROWNINGS – DEATH RATE	4	1.9
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MOTOR VEHICLE CRASH (RATE PER 100,000)	36.5	12.6
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DOMESTIC VIOLENCE (OFFENSES PER 100,000)	1,370.5	603.4
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AGGRAVATED ASSAULT (ARRESTS PER 100,000)	754.1	345.7
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LEADING CAUSES OF DEATH (AGE-ADJUSTED RATE)

CANCER	212.9	--
HEART DISEASE	184.3	--
CHRONIC LOWER RESPIRATORY DISEASE	64.6	--

BUILT ENVIRONMENT

NATURAL AMENITIES SCALE	5 OUT OF 5	
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ACCESS TO FOOD

SNAP-AUTHORIZED STORES (PER 1,000 POPULATION)	1.48	--
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WIC-AUTHORIZED STORES (PER 1,000 POPULATION)	0.14	--
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FARMERS' MARKETS (PER 1,000 POPULATION)	0.00	--
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STUDENTS FREE-LUNCH ELIGIBLE	65.45%	--
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HEALTH CARE ACCESS

LICENSED PRIMARY CARE PHYSICIANS (RATE PER 100,000)	9.4	19.7
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FAMILY PRACTICE	16.0	41.8
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INTERNISTS	4.0	7.9
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OB/GYN	5.3	14.9
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PEDIATRICIANS		
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PUTNAM COUNTY (CONTINUED)

HEALTH CARE ACCESS (CONTINUED)		
TOTAL HOSPITAL BEDS (RATE PER 100,000)	133.5	320.6
TOTAL SPECIALTY BEDS (RATE PER 100,000)	0.0	55.4
POPULATION ENROLLED IN MEDICARE	22.2%	18.0%
POPULATION ENROLLED IN MEDICAID	25.7%	15.7%
TOTAL LICENSED DENTISTS (RATE PER 100,000)	21.0	62.7
HEALTH LIFESTYLES AND BEHAVIORS		
PHYSICAL OR BEHAVIORAL HEALTH AS A BARRIER TO PHYSICAL ACTIVITY	27.2%	16.8%
MIDDLE SCHOOL STUDENTS WITHOUT SUFFICIENT PHYSICAL ACTIVITY	40.0%	30.7%
OVERWEIGHT MIDDLE SCHOOL STUDENTS (BMI AT OR ABOVE 95 TH PERCENTILE)	14.3%	11.7%
HEALTH CONDITIONS AND DISEASES		
ASTHMA HOSPITALIZATIONS - AGES 12 TO 18 (RATE PER 100,000)	411.9	330.9
DIABETES DEATHS (RATE PER 100,000)	37.4	19.3
HOSPITALIZATIONS FROM OR WITH DIABETES (RATE PER 100,000)	3,679.4	2,879.4
HOSPITALIZATIONS FROM AMPUTATION OF A LOWER EXTREMITY ATTRIBUTABLE TO DIABETES (RATE PER 100,000)	52.3	30.5
BEHAVIORAL HEALTH AND SUBSTANCE USE		
SUICIDE (RATE PER 100,000)	18.9	13.9
ADULT PSYCHIATRIC BEDS (RATE PER 100,000)	0	18.4
CURRENT SMOKERS	23.60%	17.10%
MIDDLE SCHOOL STUDENT CIGARETTE USE	12.00%	4.90%
HIGH SCHOOL SMOKELESS TOBACCO USE	11.60%	6.40%
MATERNAL AND INFANT HEALTH		
BIRTHS WITH LATE OR NO PRENATAL CARE	6.90%	5.10%
BIRTHS TO MOTHERS AGES 15 TO 19 (RATE PER 1,000 FEMALES AGE 15-19)	71.3	37.0
BIRTHS TO MOTHERS AGES 10 TO 14 (RATE PER 1,000 FEMALES AGE 15-19)	1.7	0.5

DESIGNATED HEALTH PROFESSIONAL SHORTAGE AREAS

LOW-INCOME / MIGRANT FARM WORKER

HEALTH DISPARITIES

The percentage of the population that has health insurance of any kind varies greatly across age groups. In Putnam County, residents ages 18 to 44 have a far lower percentage of insured individuals than any other group. Residents ages 65 and older are insured at a rate of more than 99 percent. Percentages of the population that are insured also vary by race, education and income levels. Black individuals are more likely to be insured, as are those with at least a high school diploma and those who make \$50,000 or more.

Overall, cancer rates are higher among White individuals than Black. Hispanic data not provided. Hypertension rates also follow this pattern. Across genders, hypertension, stroke and diabetes occur in a higher percentage of men than women. Black residents have a higher rate of coronary heart disease, stroke and diabetes than their White counterparts. Respiratory diseases, especially asthma, are highest in the Black community.

Cancer rates have fallen since 2008 in all counties except for Putnam. Putnam County is the only one in the region to see an increase in the rate of coronary heart disease from 2008 to 2010. Putnam County has the highest percentage of adults with diagnosed diabetes.

PUTNAM COUNTY (CONTINUED)

The percentage of obese individuals is highest in Putnam County. The Black community has a slightly smaller percentage of overweight or obese individuals. Nearly 40 percent of Putnam County middle and high school students do not get enough physical activity.

Putnam County had the lowest percentage of births with early prenatal care at 69.2 percent. Births with late or no prenatal care were the highest in Putnam County. Black and Hispanic women were less likely to have first trimester prenatal care, and Hispanic women were most likely to have late or no prenatal care at all. Black women were most likely to have a low birth weight baby. Putnam County's rate of Hispanic births with late or no prenatal care was more than 70 percent higher than that of the state (9.5 and 5.5, respectively).

Putnam County had the highest rate of births to young mothers ages 15 to 19 between 2008 and 2010 (71.3 rate per 1,000 females) and was nearly double that of the state rate (37 rate per 1,000). Black and Hispanic residents showed the highest rates of births to mothers ages 15 to 19 (98.1 and 85.8 per 1,000 females, respectively) and were also on the approximate order of double the state rates (57.2 and 42.2 rate per 1,000 females, respectively). The rate of births to mothers ages 10 to 14 in Putnam County (1.7 rate per 1,000 females) was more than three times that of the state rate (0.5 rate per 1,000 females).

PREVENTIVE HEALTH CARE

Generally, access to dental care declines as income declines. While the percentage of low-income persons with access to dental care in all five counties is considered low, the percentage of low-income residents accessing dental services is near the percentage for the state of Florida. The rate of adults who had permanent tooth removal due to tooth decay or gum disease was highest in Putnam County for both White and Black adults at 64.8 and 74.6 percent to the state percentages of 52.1 and 62.4, respectively. Putnam County also had the lowest percentages for dental visits and teeth cleanings; White residents visited a dentist or dental clinic and had their teeth cleaned more often than Black residents.

Survey respondents indicated that dental care is the third most frequently delayed service (behind "visit to doctor" and "medical test, exam or screening"). Putnam County has the lowest rate of licensed dentists in the Community Health Needs Assessment (CHNA) region, and only one-third of the state level. In a county of close to 75,000 people, there are only three optometrists and two audiologists. Black residents reported higher levels of good behavioral health than their White counterparts.

Rates of unintentional injury during 2010 were highest in Putnam County (86.9 per 100,000), a stark increase from the two years prior. The unintentional drowning rate is double that of the state level. The 2010 rate for motor vehicle crashes in Putnam County was the highest in the region at 36.5 per 100,000.

Immunization levels for kindergarten-aged children sat just above the state level in 2010.

Putnam County has the highest percentage of current smokers in the assessment region (23.6 percent). The percentage of middle school-age smokers is highest in Putnam County (12 percent). A much larger percentage of men smoke than women.

For some, physical barriers (i.e., disability, injury) or behavioral health difficulties make physical activity challenging. This is the case for more than a quarter of Putnam County residents.

PUTNAM COUNTY (CONTINUED)**BUILT ENVIRONMENT**

The graduation rate for Putnam County students is 75.5 percent. This is less than the state level of 80.1 percent. Additionally, the school absence data are much higher than the rest of the CHNA region, as well as the state of Florida. Gang activity (i.e., fighting, theft, vandalism, drug sales, carrying weapons) in Putnam County is overall higher than the rest of the CHNA region and the state of Florida.

Domestic violence rates in Putnam County have increased since 2008 and are double that of the state rate. The rate of aggravated assault in Putnam County is consistently above the state average. Homicide rates have stayed about the same in all counties except for Putnam, where there was a drop from 11.0 to 7.7. However, this is still above the state level.

Putnam County was given a score of "5" (out of "5") on the Natural Amenities Scale. In Putnam County there are three times as many convenience stores than all of the other types of stores (supercenters, grocery stores, specialized food stores) combined. The percentage of students eligible for free or reduced school lunch is highest in Putnam County (nearly 75 percent).

DISABILITY

The percentage of adults with disabilities is greatest in Putnam County.

ST. JOHNS COUNTY

ST. JOHNS COUNTY SELECTED STATISTICS

* ADDITIONAL COUNTY INFORMATION IN RELATIONSHIP TO OTHER COUNTIES CAN BE FOUND THROUGHOUT THE COMMUNITY HEALTH NEEDS ASSESSMENT REPORT

COUNTY HEALTH RANKINGS

HEALTH OUTCOMES	#1
HEALTH FACTORS	#1

MEASURE	COUNTY	FLORIDA
POPULATION OVERVIEW		
TOTAL POPULATION	194,400	--
RACE		
WHITE	89.3%	--
BLACK	5.6%	--
ASIAN	2.1%	--
2+ RACES	1.8%	--
OTHER	0.8%	--
ETHNICITY		
HISPANIC	5.2%	--
MEDIAN HOUSEHOLD INCOME	\$58,888	\$44,409
UNEMPLOYMENT RATE (2010)	9.5%	11.5%
PUBLIC SAFETY		
FORCIBLE SEXUAL OFFENSES (PER 100,000)	16.1	52.6
HOMICIDE (PER 100,000)	2.9	6.7
LEADING CAUSES OF DEATH (AGE-ADJUSTED RATE)		
CANCER	153.0	--
HEART DISEASE	113.3	--
CHRONIC LOWER RESPIRATORY DISEASE	34.3	--
BUILT ENVIRONMENT		
NATURAL AMENITIES SCALE	5 OUT OF 5	
ACCESS TO FOOD		
SNAP-AUTHORIZED STORES (PER 1,000 POPULATION)	0.53	--
WIC-AUTHORIZED STORES (PER 1,000 POPULATION)	0.11	--
FAST FOOD RESTAURANTS (PER 1,000 POPULATION)	0.60	--
FARMERS' MARKETS (PER 1,000 POPULATION)	0.02	--
HEALTH CARE ACCESS		
LICENSED PRIMARY CARE PHYSICIANS (RATE PER 100,000)		
FAMILY PRACTICE	14.5	19.7
INTERNISTS	28.5	41.8
OB/GYN	4.8	7.9
PEDIATRICIANS	9.1	14.9
TOTAL HOSPITAL BEDS (RATE PER 100,000)	172.9	320.6
SKILLED NURSING UNIT BEDS (RATE PER 100,000)	7.5	2
POPULATION ENROLLED IN MEDICARE	17.5%	18.0%
POPULATION ENROLLED IN MEDICAID	7.7%	15.7%
HEALTH CONDITIONS AND DISEASES		
MIDDLE SCHOOL STUDENTS WITH ASTHMA	22.80%	18.00%
BEHAVIORAL HEALTH AND SUBSTANCE USE		
SUICIDE (RATE PER 100,000)	15.9	13.9
CHILD/ADOLESCENT PSYCHIATRIC BEDS (RATE PER 100,000)	0.0	3.0
HIGH SCHOOL STUDENT CIGARETTE USE	15.70%	13.10%
BINGE DRINKING AMONG ADULTS	21.50%	15.00%
MATERNAL AND INFANT HEALTH		
BIRTHS WITH FIRST TRIMESTER PRENATAL CARE	84.90%	78.10%

ST. JOHNS COUNTY (CONTINUED)

~~DESIGNATED HEALTH PROFESSIONAL SHORTAGE AREAS~~
LOW-INCOME - WEST ST. JOHNS COUNTY

HEALTH DISPARITIES

St. Johns County respondents were most satisfied with the health care services in their county (79 percent) and submitted the highest level of "excellent" ratings (30 percent)

The percentage of the population that has health insurance of any kind varies greatly across age groups. In St. Johns County, adults ages 18 to 44 have a lower percentage of insured individuals than any other group. Residents ages 65 and older are more than 98 percent insured. Percentages of the population that are insured also vary by education and income levels. Data for Black individuals was not reported.

St. Johns County has seen a decrease in the number of licensed dentists. While the number of dentists does play a part in the accessibility of dental care, focus group participants feel that insurance coverage dictates which health services are accessible to each person, especially dentists. Residents of St. Johns County had the highest percentage of recent dental visits and the lowest percentage of having a permanent tooth removed. Data for their Black counterparts was not provided.

Affordability (a barrier to care) plays a role in the decisions for residents to take care of their health. Of those survey respondents who stated that they had delayed health care services, the three most frequently noted reasons for delaying health care treatment were "inability to pay" (38 percent), "no insurance" (35 percent) and "concerned about spending in current economy" (33 percent).

Black residents of St. Johns County present higher rates of cancer, diabetes deaths and hypertension deaths.

Males exhibit higher levels of hypertension, stroke and diabetes.

St. Johns County has the lowest infant mortality rate and lowest rate of low birth weight babies. White mothers are most likely to receive first trimester prenatal care, while Black mothers are most likely to receive little or no prenatal care. Black women are also more likely to have a low birth weight baby. Teenage mothers (ages 15 to 19) are usually Black in St. Johns County.

PREVENTIVE HEALTH CARE

St. Johns County has the lowest rate of unintentional injury, unintentional drowning and motor vehicle crashes. Levels of all three of these indicators are below the state average.

St. Johns County residents have the least amount of trouble with mental or physical barriers to physical activity. This county also sees the lowest number of students without sufficient physical activity, it is the only county that lies below the state level.

St. Johns County showed the highest levels of overall positive perception of their health and behavioral health. Binge drinking among adults had declined in all counties except for St. Johns.

ST. JOHNS COUNTY (CONTINUED)

Females are slightly more likely to smoke tobacco

St. Johns County reported the lowest levels of overweight middle and high school students

St. Johns County reported an improvement for immunizations in kindergarten-aged children from 88.6 to 91.2 percent in 2008, but continued to be lowest rate for the region. Seniors in St. Johns County boast the highest percentage of pneumonia and flu vaccinations.

BUILT ENVIRONMENT

St. Johns County has the second highest graduation rate and the second lowest level of gang activity

Domestic violence, aggravated assault, forcible sex offenses and homicide levels are all substantially lower than the state level

St. Johns County scored a “5” (out of “5”) on the Natural Amenities Scale. Additionally, it was the only county to report zero percent of children with elevated blood lead levels. Only 39 percent of the water system population gets fluoridated water.

There are substantially more full-service restaurants than fast food restaurants in St. Johns County. However, there are still only 0.02 farmers’ markets per 1,000 people and convenience stores are more common than grocery stores, specialized food stores or supercenters.

A common theme in the focus groups was the challenges presented by a lack of transportation, especially when trying to obtain health care. A handful of participants mentioned that transportation needs extend beyond getting to and from medical centers, but that is all that is provided by the public transportation system.

DISABILITY

In St. Johns County, 31.7 percent of residents ages 65 and older have a disability, this is lower than the state average of 34.2 percent and the lowest in the Community Health Needs Assessment region. The percentage of people with disabilities living in poverty is 20.7 percent, exactly the same as the state level. The percentage of adults who use special equipment due to a health problem is 7.9 percent, lower than the Florida average of 9.3 percent.



CHAPTER 11: PRIORITIZING THE NEEDS



After a thorough review and analysis of both the primary and secondary data along with the integration of the county health departments' MAPP strategic priorities, County Health Rankings and other community data, three major themes and specific community needs were identified for each hospital sector (Acute, Pediatric and Comprehensive Rehabilitation) participating in the assessment: Health Disparities, Preventive Health Care and the Built Environment. The three assessment themes reflect the collection and analysis of extensive data and are consistent with the *Healthy People 2020* National Goals and the National Prevention Strategy.

PEDIATRIC OUTCOMES

Health Disparities

(Race, Socio-Economic and Sexual Orientation)

- Infant Mortality
- Childhood Obesity
- Childhood Asthma
- Sports-Related Concussions
- Sexually Transmitted Diseases (STDs)
- Immunizations

Built Environment

- Access to Food/Food Deserts
- Education Outcomes
- Physical Activity
- Childhood Obesity
- Air Quality/Asthma
- Crime/Homicide

Preventive Health Care

- Access to KidCare
- Dental Exams and Treatment
- Eye Exams and Glasses
- Behavioral Health
 - Suicide
 - Substance Abuse
 - Marijuana
 - Binge drinking
 - Smoking and smokeless tobacco
- Unintentional Injuries
 - Drowning
 - Automobile Crashes
- Type II Childhood Diabetes
- Head Injuries

COMPREHENSIVE REHABILITATION OUTCOMES

Health Disparities

(Race, Socio-Economic and Sexual Orientation)

- Communicable Diseases
 - Influenza and Pneumonia
- Chronic Diseases
 - Prostate Cancer
 - Heart Disease
 - Hypertension
 - Congestive heart failure
 - Diabetes
 - Stroke
- Adult Obesity
- Behavioral Health

Preventive Health Care

- Health Insurance Coverage
- Prescription Assistance
- Head and Spinal Cord Injuries
- Nutrition
- Chronic Disease Health Screening
 - Hypertension
 - Diabetes
 - Heart Disease
- Unintentional Injuries
 - Motor Vehicle Crashes
- Dental Exams and Treatment
- Eye Exams and Glasses
- Behavioral Health Screening
 - Substance Abuse
 - Suicide

COMPREHENSIVE REHABILITATION OUTCOMES, CONT'D.

Built Environment

- Mobility
- Walkable Neighborhoods/Communities
- Handicapped/Disabled Person Parking Accessibility
- Access to Food/Food Deserts
- Physical Activity/Obesity

ACUTE CARE OUTCOMES

Health Disparities

(Race, Socio-Economic and Sexual Orientation)

- Infant Mortality
- Communicable Diseases
 - Sexually Transmitted Diseases (STDs), including HIV
 - Influenza and Pneumonia
 - Hepatitis
- Chronic Diseases
 - Prostate Cancer
 - Heart Disease
 - Hypertension
 - Congestive heart failure
 - Diabetes
 - Stroke
- Adult Obesity
- Substance Abuse

Preventive Health Care

- Smoking and Smokeless Tobacco
- Nutrition
- Unintentional Injuries
 - Motor Vehicle Crashes
- Dental Exams and Treatment
- Eye Exams and Glasses
- Pap Smear Screenings
- Prostate Screening
- Mammography
- Behavioral Health
 - Substance Abuse
 - Suicide

Built Environment

- Access to Food/Food Deserts
- Clean and Healthy Environment
 - Air and Water Quality
 - Asthma
 - Respiratory Illness
- Physical Activity
 - Obesity
- Transportation
- Housing
- Childhood Obesity
- Crime/Homicide

PRIORITY-SETTING AND RANKING

Members of The Partnership participated in the priority-setting process using the “Ranking” methodology. Members were asked to rank the identified themes and their respective community needs with a numerical score based on a scale of one to five (one being the most pressing need and five being the least pressing need). This exercise helped members of The Partnership develop a more complete picture of the needs and assets compared to the existing community resources dedicated to addressing each need identified.

The rankings of each hospital’s priorities were placed in a comprehensive “Priorities” table and shared with each member of The Partnership. Finally, the members of The Partnership discussed their rationale behind their respective rankings. After much discussion, negotiations on collective impact opportunities occurred as well as gaps in the community. Participants were given a chance to change their rankings accordingly.

In the end, each hospital identified and agreed upon two to five strategic health needs as their highest priority and worthy of inclusion in their respective Strategic Implementation Plans. Each hospital then engaged and/or developed employee/staff/community “implementation teams” to vet and accept the selected priorities.

Baptist Medical Center Jacksonville, Duval County

Heart Disease, Stroke, Diabetes, Nutrition, Mammogram, Infant Mortality, Behavioral Health, Smoking Cessation, Access to Food and Physical Activity

Baptist Medical Center Beaches, Duval County (specifically Atlantic, Neptune and Jacksonville Beaches)

Heart Disease, Stroke, Diabetes, Nutrition, Mammogram, Smoking Cessation, Access to Food and Physical Activity

Baptist Medical Center Nassau, Nassau County

Heart Disease, Stroke, Diabetes, Nutrition, Mammogram, Smoking Cessation, Access to Food and Physical Activity

Baptist Medical Center South, Duval and Northern St. Johns Counties

Heart Disease, Stroke, Diabetes, Nutrition, Mammogram, Infant Mortality, Smoking Cessation, Access to Food and Physical Activity

Brooks Rehabilitation, Duval and St. Johns Counties

Stroke, Head and Spinal Cord Injuries, Behavioral Health/Depression and Physical Activity

Mayo Clinic, Duval County

Adult Obesity

St. Vincent’s Medical Center Riverside, Duval, Clay and Putnam Counties

Infant Mortality, Heart Disease, Diabetes, Childhood and Adult Immunizations, KidCare, Mammogram, Type II Diabetes Screening, Access to Food, Childhood Obesity

St. Vincent’s Medical Center Southside, Duval County

Infant Mortality, Heart Disease, Childhood and Adult Immunizations, KidCare, Mammogram, Type II Diabetes Screening, Access to Food, Childhood Obesity

UF/Shands, Duval County

Infant Mortality, Heart Disease, Stroke, Diabetes, Nutrition, Mammogram, Smoking Cessation, Unintentional Injuries, Behavioral Health, Pap Smear Screening, Access to Food, Childhood Obesity

Wolfson Children's Hospital, Duval

Infant Mortality, Childhood Obesity, Asthma, Head Injury/Concussions, Sexually Transmitted Infections, Immunizations, KidCare, Eye Exams/Classes, Behavioral Health, Unintentional Injuries, Type II Diabetes Screening, Access to Food, Childhood Obesity, Physical Activity, Crime

COMMUNITY ASSETS TO ADDRESS THE NEEDS

The five counties that comprise The Partnership's service area have many resources already in place to address the health needs of the population not included in The Partnership's priority list. The Partnership recognizes the strengths of each community in the service area, and will work to support and complement organizations that are also working to improve the health and well being of the population.

Duval County Health Department, Clay County Health Department, Nassau County Health Department, Putnam County Health Department and St. Johns County Health Department each provide leadership and coordination of public health services and data collection. All five county health departments produce a Comprehensive Health Improvement Plan (CHIP) that unites service providers from across the counties in collecting and analyzing data, setting objectives and priorities, and coordinating services to reduce duplication of effort. Representatives from all five health care systems are active members on each of these CHIP community coalitions.

The Healthy Jacksonville Coalition, Partnership for a Healthier Nassau, Clay County Health Assessment Task Force, Healthy Putnam County and the St. Johns County Health Leadership Council are each working to develop comprehensive wellness plans to address the public health needs of their communities. Representatives from all five health care systems are active members on each of these coalitions.

Large and small local organizations dedicated to serving low-income and medically-underserved populations provide food, emergency financial and housing assistance, social support, and access to free or reduced-cost medical, dental, vision, hearing and behavioral health care. These organizations include, but are not limited to, the following (see next page):

CLAY	PUTNAM	ST. JOHNS
AGAPE HOUSE	AGAPE FQHC	BARNABAS CLINIC
CLAY BEHAVIORAL HEALTH CENTER	DUVAL COUNTY HEALTH DEPARTMENT	NASSAU COUNTY HEALTH DEPARTMENT
CLAY CTY. COUNCIL ON AGING (CCOA)	UNITED WAY OF NORTHEAST FLORIDA	UNITED WAY OF NORTHEAST FLORIDA
CCOA - ADULT DAY HEALTH CARE		ELC OF PUTNAM AND ST. JOHNS COUNTIES
CLAY CTY HABITAT FOR HUMANITY		KIWANIS CLUB OF PALATKA FOUNDATION
CLAY COUNTY HEALTH DEPARTMENT		MT. CARMEL COMM. RESOURCE CTR.
CLAY CTY. POLICE ACTIVITIES LEAGUE		PALATKA POLICE ATHLETIC LEAGUE
CLAY CTY. SCHOOL BOARD, PROJECT REACH KIDS PROGRAM		PALATKA MAIN STREET, INC.
CLAY CTY VICTIMS SERVICES		PUTNAM CTY. AIDS TASK FORCE, INC
CLAY TRANSIT		PUTNAM CARE COALITION
DENTAL CLINIC		PUTNAM CTY. ALCOHOL & DRUG COUNCIL
DIGNITY U WEAR FOUNDATION		PUTNAM CTY. ANTI-DRUG COALITION
DOMESTIC VIOLENCE HOTLINE		PUTNAM COUNTY HEALTH DEPARTMENT
EPISCOPAL CHILDREN'S SERVICES		PUTNAM CTY. ENVIRONMENTAL COUNCIL
FIRST COAST WOMEN'S SERVICES		UNITED WAY OF PUTNAM COUNTY
FLORIDA CONSUMER ACTION COUNCIL FOR MENTAL HEALTH		HEAL FOUNDATION
PROJECT S.O.S.		NORTH FLORIDA LAND TRUST
QUIGLEY HOUSE		PGA TOUR CHARITIES
ST. VINCENT'S HEALTHCARE		ROTARY YOUTH EXCHANGE FLORIDA
VISIÓN IS PRICÉLESS COUNCIL		SAFE PET RESCUE
THE WAY FREE CLINIC		SAFETY SHELTER OF SJIC
UNITED WAY OF NORTHEAST FLORIDA		SENIORS ON A MISSION
YMCA OF FLORIDA'S FIRST COAST		SHILOH SPIRITUAL CENTER
		SJC COUNCIL ON AGING
		ST. JOHNS COUNTY HEALTH DEPARTMENT
		ST. JOHNS HOUSING PARTNERSHIP
		THE ARC OF ST. JOHNS COUNTY
		UNITED WAY OF SJC

NEEDS NOT ADDRESSED IN ASSESSMENT

One of the top priority risk factors identified in the community health assessment—Built Environment—will not be addressed directly by hospital-led initiatives. The community health survey showed that many residents in the hospital service areas do not have pedestrian paths or grocery stores in their neighborhood. Walkability and ease of access to grocery stores can be major barriers to regular participation in physical activity and access to fresh fruits and vegetables. That said, none of the participating hospital partners are in a position to directly impact these issues. However, all of the partners are committed to improving the health and wellness of our communities, and fully support local government and wellness coalitions in their efforts to positively impact these issues.

Transportation effects access to care, particularly among the low-income and medically-underserved populations. Other local organizations such as the Area Agency on Aging, Council on Aging and local transportation systems are already working to address transportation needs in the area. Therefore, the participating partners will not directly address this issue with any new initiatives.

COMMUNITY NEEDS ASSESSMENT TAKEAWAYS

The Jacksonville Metropolitan Community Benefit Partnership's community health assessment includes a wealth of data from both primary and secondary sources about the health and well-being of residents of the five-county area covered by the community health needs assessment. It also identifies a number of areas of concern, which should lead to further investigation and continued collaborative action among the Partners. Participants of this multi-system Partnership developed transformative and unprecedented takeaways from this collaborative assessment process. Throughout the assessment, The Partnership discovered areas for future community benefit collaboration they identified areas of overlap and duplication among the systems and county health departments, community-based organizations and local government, areas where additional services are needed, and areas primed for intense “collective impact” strategies such as addressing the epidemic of obesity.

Further Takeaways

- The Northeast Florida's health, human service, aging, disability, environmental and philanthropic community should align community benefit programs and funding patterns with the priorities and key findings of The Partnership's community needs assessment.
- The Northeast Florida's population health status should be tracked, measured and monitored through the Northeast Florida Counts health-related quality of life indicator platform.
- [†]Access to Health Care was identified by The Partnership as the single most important issue in Northeast Florida.
- Health care and community health should evolve from a system of sick care to one based on wellness and prevention.
- The Northeast Florida health community should embrace a holistic approach (physical, emotional, place, mind and spirit) to improve individual health outcomes.

[†] Access to Health Care is defined as Any person who is insured, underinsured or uninsured who has a disruption or barrier to obtaining information on community resources, obtaining affordable health, dental, behavioral health insurance coverage, obtaining durable medical equipment, obtaining transportation, filling prescriptions or securing a primary care physician.

APPENDICES

COMMUNITY HEALTH SURVEY 2012 DEMOGRAPHICS

RESPONDENTS	TOTAL	COUNTY			
		CLAY	DUVAL	NASSAU	ST. JOHNS
NUMBER	934	123	605	49	157
PERCENT	100%	13.2%	64.8%	5.2%	16.8%

NUMBERS TAKEN FROM "HOW LONG HAVE YOU LIVED IN YOUR COUNTY?"

GENDER	TOTAL (N = 934)	COUNTY			
		CLAY (N = 121)	DUVAL (N = 605)	NASSAU (N = 49)	ST. JOHNS (N = 157)
MALE	34	32	33	33	41
FEMALE	66	68	67	67	59
TOTAL	100%	100%	100%	100%	100%

AGE	TOTAL (N = 934)	COUNTY			
		CLAY (N = 121)	DUVAL (N = 605)	NASSAU (N = 49)	ST. JOHNS (N = 157)
18 TO 24	12	10	13	15	7
25 TO 34	19	12	22	8	12
35 TO 44	18	18	19	15	16
45 TO 54	20	26	19	17	21
55 TO 64	15	18	14	19	18
65 TO 74	8	12	6	12	15
75 TO 84	6	4	5	15	8
85 AND OLDER	1	1	1	0	3
TOTAL	100%	100%	100%	100%	100%

*DATA ROUNDED

COMMUNITY HEALTH SURVEY 2012 DEMOGRAPHICS (CONTINUED)

RACE/ETHNIC IDENTIFICATION	TOTAL	COUNTY			
	(N = 920)	CLAY	DUVAL	MASSAU	ST. JOHNS
WHITE	75	88	68	93	93
AFRICAN-AMERICAN	16	5	22	5	1
ASIAN	3	2	4	0	1
OTHER/MULTI-RACIAL	2	2	3	0	2
HISPANIC	3	2	3	0	4
TOTAL	100%	100%	100%	100%	100%

*DATA ROUNDED

HISPANIC HERITAGE	TOTAL	COUNTY			
	(N = 931)	CLAY	DUVAL	MASSAU	ST. JOHNS
YES	3	2	3	2	4
NO	97	98	97	98	96
TOTAL	100%	100%	100%	100%	100%

COMMUNITY HEALTH SURVEY 2012 DEMOGRAPHICS (CONTINUED)

	TOTAL (N = 933)	CLAY (N = 129)	DUVAL (N = 606)	COUNTY	
				NASSAU (N = 493)	ST. JOHNS (N = 150)
EMPLOYMENT					
EMPLOYED - FULL-TIME	43	38	45	29	8
EMPLOYED - PART-TIME	10	13	9	31	27
RETIRED	19	23	15	6	9
FULL-TIME HOMEMAKER	6	5	6	3	3
DISABLED	4	3	4	3	4
NOT EMPLOYED AND LOOKING FOR WORK	9	10	10	1	2
NOT EMPLOYED AND NOT LOOKING FOR WORK	1	0	1	10	4
FULL-TIME STUDENT	6	2	9	0	0
MILITARY	1	3	1	0	3
OTHER	1	2	1	100%	100%
TOTAL	100%	100%	100%	100%	100%
DATA ROUNDED					

	TOTAL (N = 903)	CLAY (N = 118)	DUVAL (N = 591)	COUNTY	
				NASSAU (N = 46)	ST. JOHNS (N = 150)
INCOME					
LESS THAN \$15,000	9	4	10	7	4
\$15,000 TO \$24,999	11	10	13	12	5
\$25,000 TO \$34,999	11	9	11	19	8
\$35,000 TO \$49,999	18	11	21	8	12
\$50,000 TO \$74,999	24	33	22	15	31
\$75,000 TO \$99,999	12	11	12	14	14
\$100,000 OR MORE	15	22	11	26	25
TOTAL	100%	100%	100%	100%	100%
DATA ROUNDED					

COMMUNITY HEALTH SURVEY 2012 DEMOGRAPHICS (CONTINUED)

HIGHEST GRADE OF SCHOOL COMPLETED	TOTAL (N = 933)	COUNTY			
		CLAY (N = 123)	DUVAL (N = 604)	NASSAU (N = 49)	ST. JOHNS (N = 157)
NEVER ATTENDED SCHOOL OR ONLY ATTENDED KINDERGARTEN	0	0	0	0	0
GRADES 1 THROUGH 8 (ELEMENTARY)	0	0	0	0	0
GRADES 9 THROUGH 11 (SOME HIGH SCHOOL)	2	2	2	0	0
GRADE 12 OR GED (HIGH SCHOOL GRADUATE)	17	18	19	3	0
COLLEGE 1 YEAR TO 3 YEARS, NO DEGREE (SOME COLLEGE OR TECHNICAL SCHOOL)	25	25	26	14	10
TWO-YEAR COLLEGE DEGREE (AA, AS)	11	15	11	30	21
COLLEGE, 4 YEARS OR MORE WITH DEGREE (BA, BS)	29	31	28	8	13
GRADUATE DEGREE (MASTERS OR PHD) OR OTHER	14	10	13	26	34
TOTAL	1	2	0	19	21
DATA ROUNDED	100%	100%	100%	100%	100%

FORECLOSURES IN THE LAST YEAR	TOTAL (N = 920)	COUNTY			
		CLAY (N = 123)	DUVAL (N = 601)	NASSAU (N = 49)	ST. JOHNS (N = 156)
YES	3	7	3	0	2
NO	96	93	96	100	98
NOT SURE	0	0	0	0	0
REFUSED	0	0	0	0	0
TOTAL	100%	100%	100%	100%	100%
DATA ROUNDED					

COMMUNITY HEALTH SURVEY 2012 DEMOGRAPHICS (CONTINUED)

SEXUAL ORIENTATION	TOTAL	CLAY	DUVAL	COUNTY	ST. JOHNS
	(N = 833)	(N = 112)	(N = 516)	(N = 42)	
GAY OR LESBIAN	3	0	4	0	0
BISEXUAL	3	2	4	0	1
HETEROSEXUAL OR STRAIGHT	95	98	92	100	99
TOTAL	100%	100%	100%	100%	100%

DATA ROUNDED

COMMUNITY HEALTH FOCUS GROUP 2012 DEMOGRAPHICS

RESPONDENTS	TOTAL	CLAY	DUVAL	COUNTY	ST. JOHNS
	NUMBER	6	122	7	
PERCENT	100%	4%	82%	5%	9%

GENDER	TOTAL	CLAY	DUVAL	COUNTY	ST. JOHNS
	(N = 148)	(N = 6)	(N = 122)	(N = 7)	
MALE	43%	33%	41%	43%	54%
FEMALE	57%	67%	60%	57%	46%

AGE	TOTAL	CLAY	DUVAL	COUNTY	ST. JOHNS
	(N = 148)	(N = 6)	(N = 122)	(N = 7)	
UNDER 18	1%	0%	6%	0%	0%
18 TO 29	13%	0%	7%	29%	15%
30 TO 46	34%	33%	37%	14%	54%
47 TO 65	48%	67%	35%	57%	31%
66 TO 84	4%	0%	16%	0%	0%
85 AND OLDER	0%	0%	0%	0%	0%

COMMUNITY HEALTH FOCUS GROUP 2012 DEMOGRAPHICS (CONTINUED)

RACE	TOTAL		COUNTY		ST. JOHNS (N = 13)
	(N = 147)	(N = 6)	(N = 122)	(N = 6)	
BLACK, AFRICAN AMERICAN	10%	17%	14%	0%	8%
WHITE, CAUCASIAN	68%	67%	79%	50%	77%
AMERICAN INDIAN OR ALASKA NATIVE	0%	0%	0%	0%	0%
ASIAN OR PACIFIC ISLANDER	0%	0%	1%	0%	0%
OTHER	22%	17%	7%	50%	15%

DATA ROUNDED

SPANISH/ HISPANIC/LATINO	TOTAL		COUNTY		ST. JOHNS (N = 13)
	(N = 147)	(N = 6)	(N = 122)	(N = 6)	
YES	25%	33%	8%	57%	0%
NO	74%	67%	92%	43%	96%

DATA ROUNDED

SEXUAL ORIENTATION	TOTAL		COUNTY		ST. JOHNS (N = 13)
	(N = 147)	(N = 6)	(N = 122)	(N = 6)	
HETEROSEXUAL OR STRAIGHT	100%	100%	100%	100%	100%
GAY OR LESBIAN	0%	0%	0%	0%	0%
BISEXUAL	0%	0%	0%	0%	0%

HOUSEHOLD INCOME	TOTAL		COUNTY		ST. JOHNS (N = 13)
	(N = 138)	(N = 6)	(N = 122)	(N = 6)	
LESS THAN \$15,000	40%	50%	13%	29%	69%
\$15,000 TO \$24,999	29%	17%	12%	57%	31%
\$25,000 TO \$49,999	15%	33%	25%	0%	0%
\$50,000 TO \$74,999	8%	0%	18%	14%	0%
\$75,000 TO \$99,999	3%	0%	11%	0%	0%
\$100,000 OR MORE	6%	0%	22%	0%	0%

DATA ROUNDED

COMMUNITY HEALTH FOCUS GROUP 2012 DEMOGRAPHICS (CONTINUED)

MARITAL STATUS	TOTAL	COUNTY			
		CLAY	DUVAL	NASSAU	ST. JOHNS
SINGLE	15%	0%	22%	29%	8%
MARRIED	63%	67%	59%	71%	54%
DIVORCED	17%	33%	13%	0%	23%
WIDOWED	3%	0%	4%	0%	8%
LIVING TOGETHER, NOT MARRIED	3%	0%	3%	0%	8%

DATA ROUNDED

EMPLOYMENT	TOTAL	COUNTY			
		CLAY	DUVAL	NASSAU	ST. JOHNS
FULLY RETIRED	19%	0%	20%	0%	54%
WORKING FULL-TIME FOR PAY	13%	0%	40%	14%	0%
WORKING PART-TIME FOR PAY	18%	33%	18%	14%	8%
UNEMPLOYED, LOOKING FOR PAID WORK	31%	50%	9%	43%	23%
NOT LOOKING FOR WORK	19%	17%	13%	29%	15%

DATA ROUNDED

HEALTH INSURANCE	TOTAL	COUNTY			
		CLAY	DUVAL	NASSAU	ST. JOHNS
PRIVATE INSURANCE	32%	0%	52%	0%	77%
MEDICARE	7%	0%	29%	0%	0%
MEDICAID	10%	17%	9%	0%	15%
OTHER	46%	67%	15%	100%	0%

JACKSONVILLE METROPOLITAN COMMUNITY BENEFIT PARTNERSHIP
SHANDS MINORITY FOCUS GROUP – THEMES AND SUMMARY

1. What do people in your community do to stay healthy? For example, to exercise, where they get information about health, checkups, health screenings, safety, biking, walking, where they get access to healthy foods, and those types of things.
 - Information is transgenerational – it comes from mothers, home remedies, etc
 - Exercise is not a real priority, but the jobs that those in the community hold are labor intensive (i.e., construction, cleaning)
 - Those who take the bus do a lot of walking
 - Some people exercise by walking in the park
 - Medical assistance is very limited for those without papers
 - Access to healthy foods provided by WIC
2. Is this a good place to raise children: school quality, daycare, after-school care, recreation, natural environment, that kind of thing?
 - Conflicting ideas about safety one says it feels safe and another says the community does not feel safe – high crime and violence
 - Schools are seen in a positive light because they are free and can provide meals for children
 - Language barrier is an issue for parents They do not know what their children are learning and cannot be involved
3. What about daycare, when both parents have to work and the kids are not old enough for school?
 - Little to no access to free daycare or subsidized formal daycare
 - Latino community works together to help take care of children There is “a lot of cohesiveness”
4. Do you feel that there's economic opportunity in the community: locally-owned and operated businesses, jobs with career growth and job training, higher educational opportunities, affordable housing options?
 - Limited economic opportunity Free English classes are the extent of services
 - Not having proper documentation is a problem for even the most basic things such as renting housing
5. Where do you or most of your neighbors go for health care services: doctors, emergency rooms, health clinic, health department, home health care services, etc.?
 - Pregnant women and most Hispanic individuals go to the Health Department
 - If they are not pregnant, they simply do not go because there are not many free services Most of the free clinics that do exist require a social security number
6. Are there health services that you need that are not available to you? You could consider primary care, specialty care, dental/oral care, family planning, birth control, behavioral health, prescription medications, substance abuse — any services that are not available to you.
 - Access to all services is limited, but the two most significant are dental and behavioral health services
7. Have you personally experienced any trouble with doctors not accepting Medicaid or self-pay?
 - It does not seem as though people have trouble finding a doctor that will accept self-pay However, due to the low income of most residents, paying for a visit alone (without any tests/lab work) is too expensive.

SHANDS MINORITY FOCUS GROUP – THEMES AND SUMMARY

8. How do you or your neighbors pay for their health care services?
 - Cash
 - Without insurance, they simply do not go to the doctor
9. How has the local economy affected you or your neighbors' health?
 - Because most people work in construction, the decline in work in that field has really affected the community
 - Many people will wait until the last 40 days of pregnancy to see a doctor so that they can use Medicaid benefits (you can get Medicaid for 45 days if you are pregnant)
 - They do not go to the doctor unless it is a real emergency because they cannot pay
10. What prevents you or your neighbors, friends and family members in your community from taking care of yourselves and staying healthy in general?
 - The price of health food, especially without WIC
 - Price in general
11. What influences your decision to take care of your health: money, doctor, family members, health insurance, transportation, church, etc.?
 - Transportation and money Even with a car, gas prices are very high. The majority of the Hispanic population lacks transportation, so the bus is the usual mode of transportation.
 - Access to and price of healthy foods
 - Cultural influences on diet choices (i.e., high levels of carbohydrates in Latino cultural foods such as tortillas, rice, corn)
12. Do you feel like your neighborhood is easy to get around in by bicycle or on foot; do you have destinations to go to without using a car?
 - Walking distance (i.e., from the hospital to Publix)
13. The physical environment, do you feel that the air is clean, the water is clean, those sorts of things?
 - Yes, it is clean
14. Do you think there's education being provided to children about what their healthy food choices are, education about diet and nutrition? Do you feel like that's accessible to the community?
 - The children receive education in schools, but the parents do not receive it

Conclusions

- Lack of documentation of legal status is a major barrier to all aspects of life, especially access to health care.
- Opportunities for healthy diet choices are limited, even with WIC. Education about food is present in schools, but the parents are not being educated. Additionally, cultural food norms play a part in food choices
- Job losses and the economic climate have put health care services even further out of reach, so much so that many people choose not to see a doctor at all.
- The lack of transportation leads to an increase in the amount of walking that individuals do, however, that benefit is outweighed by the fact that it also serves as a major barrier to access to health care
- The most pervasive theme is cost of care

HEALTH NEEDS ASSESSMENT FOCUS GROUP
BROOKS REHABILITATION – SUMMARY AND CONCLUSIONS

BLUE = DISABILITY RED = STROKE ORANGE = BRAIN INJURY

- 1. What do people in your community do to stay healthy? It could be your neighborhood, county, define it as you like?**
 - Since 2007, the Brooks sports program has provided opportunities for individuals to stay active (i.e., rowing, soccer, bowling, hand cycle)
 - Getting active, especially with others with disabilities, has had a positive impact on their behavioral health as well. They no longer feel like they are alone and have something to occupy their time. Keeping busy lifts their spirits
 - That being said, aside from Brooks, Jacksonville is not the ideal place for someone new to a disability. The city is very large and public transportation is not very accessible
 - YMCA and Brooks for exercise
 - If they live near schools, many people walk the track. Parks are too far away.
 - Walking, especially with their dogs
 - Private gyms and the YMCA
 - Feel safe walking, but not biking due to lack of bike-friendly infrastructure
 - Shop at health food stores (i.e., Whole Foods, Native Sun, GNC)
 - Lifting weights
 - Walking, running
 - Cooking healthy meals

- 2. Are there any additional elements that you would add to the Brooks recreation program?**
 - More staff and more money. Services seek to expand, but the staff does not expand in sync so resources get spread thin. As more and more people with disabilities find out about the program and the things they can be involved in, more and more people participate, but this requires additional staff or volunteers
 - The activities are held at different locations throughout the city. If there was one centralized facility, transportation would be easier
 - Transportation services are frustrating. The individual is given a two-hour wait span, but the driver does not wait at all if you are not there right when they arrive

- 3. Where do you seek health information to find out about health or health services?**
 - The Internet (i.e., Google)
 - Sharing information with others met through the activities

- 4. I heard mention of the pattern of going to work and coming home and the weight gain. When you talk about nutrition, do you feel that you have access to healthy food stores, and where do you get nutrition information?**
 - Sometimes reaching things on store shelves is difficult
 - Cooking at home is a challenge. It is difficult to get something off of the stove or out of the oven
 - Often it is much easier and less time-consuming to purchase something that is pre-made
 - Due to low income, money is always a concern. Unfortunately, the cheapest food is usually not the healthiest
 - Weight gain is a concern for those with limited mobility. The standard 2,000 calories a day is more than they need and can lead to weight gain
 - Some believe that Brooks should spend more time on education about these issues

BROOKS REHABILITATION – SUMMARY AND CONCLUSIONS

5. So, about how many individuals are part of your community here in Jacksonville?

- In Duval County there are approximately 60,000 people with disabilities
- That includes ADA disabilities. The numbers for physical or mobility impairments are self-disclosed so they could be higher

6. How large is your group here at Brooks?

- The program served about 1,000 people last year (50 people per week across 14 activities)

7. Do you feel there is economic opportunity in the Jacksonville community in terms of job growth, opportunity to start your own business, higher education opportunities, affordable housing?

- Not enough. Jobs are growing, but not at the same rate for working-age people with disabilities
- With limited income comes limited housing opportunity. Paired with accessibility issues, this issue is very difficult
- The lack of transitional housing plays a part as well. There is a large gap between limited income and getting a job to increase their income
- Housing is affordable and job opportunities reflect the economy, but are not too limited
- There are not as many jobs with career growth and job training as there used to be
- Good higher education opportunities (UNF, JU)
- There is a lot of affordable housing, but it depends on how you define affordable
- If you are willing to work hard, there are plenty of opportunities (in reference to higher education)
- There is affordable housing, but not in the best areas

8. Do you feel the community is a safe place to live?

- Yes, for the most part, but there are some exceptions by location (i.e., Regency Mall)
- For the most part, neighbors look out for each other
- Yes, in the areas that they reside. Other areas are not the same (i.e., Regency)
- The neighbors in their community watch after each other since most of them are retired
- Overall, yes
- Neighbors look out for one another

9. What about educational opportunities here in Jacksonville?

- There are quality higher education options, but DCPS is "not that good"
- The university systems offer a satisfactory amount of disabled services. UNF in particular has a new resource center

10. Where do you or most of your neighbors go for health care services, primary care and specialty care?

- Memorial Hospital
- Primary care physician
- Solantic, especially if the reason for going is unrelated to their disability
- Wait times play a part. Additionally, they have to find someone who is not only in their insurance network, but is familiar with their disability
- The Internet does not provide much guidance on finding a doctor. They rely heavily on word of mouth within the community

BROOKS REHABILITATION – SUMMARY AND CONCLUSIONS

- A disability directory (broken down by insurance and/or location) would be very helpful
- Most respondents had a primary care physician that they would see. Emergency room used for emergencies, not because they do not have doctors
- Urgent care centers are used after-hours, but the wait is very long
- Private doctors. Nobody that they know uses a health clinic or the Health Department. Do not know anyone that would go to the emergency room for a non-emergency. Solantic on Sundays.
- Most have private physicians and specialists affiliated with the hospitals

11. What about emergency room care; which ERs do you go to?

- It depends on whether the emergency is based on their disability or not. Memorial and Shands for spinal injuries. Many of the doctors that Brooks patients see are affiliated with Memorial
- St. Luke's and Baptist
- Baptist, St. Vincent's, St. Luke's
- Baptist Shands Mayo, Orange Park

12. What are some of the reasons that you've visited the emergency room?

- Pressure sores
- Heart condition
- Staph infection
- These issues are not always related to their disability
- Some see others use the ER for emergencies only and others know of people who go for non-emergency reasons

13. What about home health services?

- It would be nice, but insurance does not pay for it.

14. Are there health services that you need that are not available to you; can be primary care, specialty care, dental, family planning?

- Yes, all of the above.
- Exam rooms are not accessible/disability-friendly (tables too high off the ground, no trained personnel to help get you on the table)
- "No problems at all"
- "None that [they] need"
- Occupational and physical therapy (because they do not accept Medicaid)
- Dental health

15. Have you personally ever experienced any trouble with doctors accepting Medicaid or not accepting you because you did not have insurance?

- Medicaid restricts patients from seeing the doctors they want to see. Even once they decided on a doctor, their wait-time was anywhere from one to three hours
- Frustration that their insurance won't allow them to go to Brooks, but an unemployed individual could
- It is nearly impossible to find a doctor that will let you pay out of pocket because they want to charge the insurance company
- In general, no Medicare advantage requires that they do a bit more searching to find a doctor that will accept it
- Yes, for physical and occupational therapy

BROOKS REHABILITATION – SUMMARY AND CONCLUSIONS

16. How do you or your neighbors pay for health care services?

- Mostly private insurance (employer-provided)
- Typically, through private insurance and Medicare
- Private insurance and/or Medicare Advantage

17. Has the local economy affected your ability to cover your health care expenses, and in what way?

- Yes. Most of them are living on a fixed income (disability check)
- It is common for a medical item to be more expensive, if purchased through insurance versus paying out-of-pocket
- Durable medical equipment is extremely overpriced
- They feel a double-squeeze, when the economy is bad, they feel the same economic pressures as everyone else, but they also have to face increasing costs of medical equipment
- Some job loss but overall, relatively unaffected
- Personally, unaffected. Has seen issues with decline in military health service
- Fewer jobs, hard to compete after sustaining a brain injury

18. Do you feel that the economy prevents you from taking care of yourself the way that you would want to?

- Yes. Reusing catheters is a common example
- Simple, but necessary things, often are not covered i.e. shower chairs

19. Think about you, your neighbors, friends, and family members in your community. What prevents you from taking care of yourselves (or staying healthy)?

- Independence (or lack thereof), if you are scared of injury (i.e. falling), you tend to stay put
- Transportation: JTA “can be a problem.” The wait-times are long and the workers do not do much to ensure that you get the services you have requested. Some have been denied use of the services because they own a car, even though doctors have said they cannot drive
- Nothing but ourselves. We have all of the resources, we just have to use them
- Lack of mobility due to brain injury

20. In thinking about you, your neighbors, family and friends, what influences your decisions to take care of your health?

- Cost
- Availability
- Support system (family, friends, church members) and the will to get better
- Family members (some who are doctors) and information about screenings in the newspaper
- Support system (family, friends, doctors)

21. In terms of decisions you make about your health care, is it usually a shared decision, not individual, for those of you who are married or have a partner?

- Definitely a shared decision

22. What about your faith, religion, church, God, if that is your spiritual path; does that in any way influence your health care decision-making?

- Prayer plays a big part.

BROOKS REHABILITATION – SUMMARY AND CONCLUSIONS

23. Is there anything else you'd like to tell us or talk about?

- Transportation is a huge obstacle. People either do not have a ramp to leave their house, or do not have reliable transportation. Brooks has a small budget for this, but it is not enough, and JTA "is not the answer".
- Family doctors are very important
- Public transportation from Clay County to Jacksonville should be improved

CONCLUSIONS

Both similarities and differences exist in themes across respondent type

Commonalities:

- Transportation is a large barrier to health care services and overall well being. Public transportation (JTA) does not provide adequate assistance
- Overall, people feel the community is safe. The exceptions lie in pockets of the community (i.e., Regency)
- Nearly all respondents acknowledged the quality opportunities for higher education
- Most respondents utilized a private physician, but knew of individuals who sought care from emergency rooms for non-emergencies. Solantic was also mentioned frequently, but mostly utilized during off-peak times (nights and weekends)
- In addition, most respondents stated that they or their neighbors typically used private insurance or Medicare to cover their health care expenses
- Support systems play a crucial role in health care decision-making. Respondents pointed most frequently to family members (either they urge them to be healthy or are the motivation for personal choices), friends/social pressures to be healthy and doctors

Differences:

- Those with disabilities face not only low income, but expensive medical equipment and accessibility issues in housing, transportation and even exam rooms
- Those with disabilities have formed a community where they share medical information with each other and form a de facto support group
- Those who have suffered brain injury would like more assistance when it comes to occupational and physical therapy
- All respondent types with the exception of those with disabilities viewed the local economy as having minimal impact on opportunity and availability of affordable housing. They believe that the job market has gotten slightly smaller, and that affordable housing is available. However, they note that "affordable" means different things to different people, and affordable housing typically is not in the best areas of town
- Those affected by stroke, as well as caregivers, did not feel that they had health needs that were not being met.

HEALTH NEEDS ASSESSMENT FOCUS GROUP
MAYO CLINIC — SUMMARY AND CONCLUSIONS

BLACK — GENERAL RED — CANCER GREEN — LIVER/KIDNEY

1. What do people in your community do to stay healthy; for example, exercising, or wherever they get information about their health, health screenings, etc.?

- Gardening
- Golfing and riding bikes
- Water sports
- Walking/jogging/running
- It is easy to be healthy There is a community sentiment that being healthy is important
- Not everyone has the advantage of seeing their physicians/dentists as often as they should
- Exercising by going to the gym, walking, jogging
- Regular doctor appointments
- YMCA, walking dogs and walking on the beach for exercise
- Health information comes from television (Dr. Oz) and the Internet.

2. Do you feel like your community is a good place to live and raise children, does it feel safe to raise children?

- Yes, in guarded (not gated) community
- Good community events (community-wide picnic).
- St. Johns County provides quality schools and is a safe place
- The schools here are not as high-quality as ones up North
- Duval County does not have very good schools, so you have to use private schools
- The quality of education affects health (i.e., nutritional choices, job opportunities)
- Very safe place, but there are pockets that are not so safe (i.e., Springfield, NW Duval County)
- Mandarin, Sawgrass and Ponte Vedra are all considered safe
- Putnam County sees high robberies/vandalism, but still feel safe walking around the neighborhood
- Wildlife is a concern (snakes and alligators)
- Yes.

3. And do you have any criticisms about where you live?

- Increase in taxes due to addition of LPGA

4. Do you feel that there is economic opportunity in your communities?

- No, not in Duval or St. Johns County
- Jacksonville is better off than a lot of other places (e.g., colleges, hospitals, constant construction, the port)

5. Where do most of your neighbors or you go for health care services? For example, a doctor, emergency room, health care clinic, home health care services, that type of thing?

- Mayo or Baptist
- Mayo, Memorial and Baptist
- For non-hospital services, people go to Solantic or primary care physicians
- The one respondent who does everything at Mayo enjoys having all of their information in one system.

MAYO CLINIC — SUMMARY AND CONCLUSIONS

- Mayo Clinic
 - Urgent care facilities are convenient and much less expensive.
6. Do you feel that there are any health services that are not accessible to you? For example, dental, primary care, any sort of specialty care, behavioral health, substance abuse, prescription meds?
- Volusia County behavioral health services are not sufficient. The people who want help don't have the opportunity to get it because all facilities are filled with court-mandated individuals
 - Alternative medicine (i.e., holistic center, massage, acupuncture, meditation)
 - Insurance coverage dictates these things, especially dentists
 - Mammograms require that you wait a couple of months, unless you have special circumstances
 - When you first come to town it can be difficult, but the service providers are here
7. Do you feel that you could use more, in terms of capacity, that there could be more services for behavioral health; or do you feel it's part of that system of who they are serving?
- Frustrated with having to go into Downtown Jacksonville from the beaches for things like courthouse services
8. Have you or anyone you know ever experienced any trouble with doctors accepting Medicaid, Medicare or self-pay?
- Without health insurance, it is difficult to get services anywhere for anybody unless you go to the emergency room
 - Mayo does not accept Medicare.
 - Yes, Mayo is often not in the network for Medicare
 - Finding a doctor in the Medicare network takes some searching.
 - Often switch to generic drugs to save money.
9. How has the local economy affected you or your neighbors' health?
- View high uninsured rate as being direct consequence of loss of jobs
 - Those with insurance notice decrease in coverage and increase in premiums and co-pays
 - There are a lot of people who make too much to qualify for Medicaid, but can't afford premiums.
 - Most respondents have fared well, but they have noticed an increase in stress (e.g., higher cost of food, finances troubles leading to divorce, suicide)
 - Many people struggle with job loss and/or increased premiums
 - The cost of transportation is increasing, so the cost of healthy food is increasing
 - Health insurance has gone up. The health care isn't the problem, it's the insurance
10. How do you or your neighbors pay for your health care services?
- Private insurance (mostly employer-provided)
 - Medicare
 - VA
11. Do you think that someone having insurance would make them go to a family doctor more often?
- Unanimous "yes"

MAYO CLINIC — SUMMARY AND CONCLUSIONS

12. Thinking about you, your neighbors, friends and family, what would prevent you from taking care of yourself and staying healthy?

- Accessibility and transportation Because there is no bus system, they must rely on taxis. Additionally, they must use taxis if they don't have a caregiver during recovery from a procedure
- People do without health care because they can't get Medicaid or Medicare
- Transportation needs extend beyond getting to and from medical centers, and that's all that JTA covers.
- Lack of insurance
- Time constraints of dual-earner family with children
- Lack of time
- Having to hunt for service providers in your insurance network
- Affordability, especially if the patient is young, they will put off seeing a doctor if they have to pay
- The older people are more conscious of being healthy

13. Thinking again about you, your neighbors, friends and family, what influences your decision to take care of your health? Another person, doctors, a pastor, if you have insurance, other family members, money, things like that?

- What your insurance covers
- The cost of medication
- Knowledge of health issues and symptoms
- Knowing your body and knowing when something is wrong
- Social pressures from family and doctors
- Personal values/emphasis on personal wellness
- Seeing others around you getting sick and not recovering well
- Being a role model and being around to see children/grandchildren grow up

14. Is there anything else that we haven't hit on that would address the health and wellness of your community?

- Very few people in the produce section at the supermarket. With time constraints, everyone makes their way to the freezer section
- Plenty of outreach to elderly, but not screenings and prevention for parents with kids
- There should be more education for young families on things such as nutrition and preventive screenings
- One respondent acknowledged that their responses are based on their environment in a wealthy community and are likely not an accurate reflection of the greater Jacksonville community.
- Paperwork is complicated. Suggestions included making the process simpler and educating those who fill it out
- Education is the way to change people's minds about what cheap food is

CONCLUSIONS

- Respondents live in a community that places an emphasis on regular exercise. Not only do the people encourage it, but the built environment allows for it, too.
- For the most part, respondents felt that their community was safe. Many lived on golf courses or in gated communities.
- Some feel that there are not economic opportunities, but others see the economic conditions in Jacksonville as more resilient than most other places.
- Many people go to Mayo or urgent care centers.
- Insurance coverage dictates the services one receives, especially when it comes to dental care.
- Cancer patients notice the absence of alternative medicine options.
- Loss of employment paired with the increased costs associated with insurance lead people to struggle.
- The fact that Mayo does not accept Medicare came up quite often.
- Time constraints, transportation and affordability (especially when uninsured) are the major barriers.
- Social relationships strongly influence decisions about health.

JACKSONVILLE METROPOLITAN COMMUNITY BENEFIT PARTNERSHIP
BAPTIST HEALTH – SUMMARY AND CONCLUSIONS

1. **What do people do in your community to stay healthy?**
 - Go to the gym
 - Walking at local parks/at the school track
 - YMCA
 - Childhood immunizations
 - Eating right and exercising
 - Visit the doctor regularly for checkups
 - Try to shop at health food stores, but they are expensive. Farmers' markets are good for produce, but they require a separate trip
 - To get information, they go to seminars, receive information from their doctors, the Internet and from each other
 - Relax on the weekend to decrease stress
 - Healthy food from gardens/markets
2. **Is this a good place to raise children?**
 - There are many issues with the schools (e.g., lack of funding for school activities, after-school programs, and transportation; lack of positive reinforcement) Magnet schools are good
 - Yes, dependent on the neighborhood NW Jacksonville is not a safe area to raise children
 - Children with special needs don't have many options
 - It depends on the age of your child, the elementary schools are good, but the middle and high schools lose quality, mostly due to the number of children per school
3. **Do you feel there is economic opportunity in the community?**
 - The job market is rough, especially in the manual labor intensive jobs (i.e., construction)
 - Higher education opportunities exist with the universities
 - Affordable housing is available because of all the foreclosures. The problem is getting loans
 - There is wide variation in answering this question because Jacksonville is so large, there are pockets of good and bad
 - There are not many small businesses. They are generally tucked away and word-of-mouth is the only way to find them.
 - The big companies are pushing out small businesses
 - Yes and no to affordable housing. The housing market is now cheaper, but rental prices have gone up and assisted living is not affordable
 - The jobs that are available pay minimum wage and provide no benefits
4. **Do you feel that your community is a safe place to live?**
 - The neighbors don't look out for one another. And in neighborhoods where they do, the schools are not safe (low security in a high-crime area)
 - Overall, yes. However, there are a lot of pockets of unsafe areas
 - While some areas might be worse than others, some issues are everywhere (i.e., sex offenders).
 - Even with neighbors you can trust, you still never know when someone may try to break into your house
 - Yes, they feel safe where they live and work, but not at the schools that their children attend. Schools in high-crime areas (i.e., magnet schools) do not make them feel safe
 - Overall, they feel safe in parks, but would not let their children go unsupervised

BAPTIST HEALTH – SUMMARY AND CONCLUSIONS

- For the most part, people felt that their neighbors looked out for them
 - Gateway and Regency Malls are not considered safe, while the Avenues and Town Center are.
 - They feel safe at the beach because you get to know your neighbors more than in other areas. Their neighbors look out for them
 - They feel safe at home and sometimes at school. Some schools are in high-crime areas or lack the security measures to keep danger out of the school
- 5. Where do you or most of your neighbors go for health care services?**
- When people don't have insurance, they go to the emergency room. At Shands, they can apply for a clinic card
 - Many people also go to the Health Department, if they have the right paperwork.
 - If you are from here, are poor, and have papers, you get Medicaid
 - Private physician or urgent care center, if needed
 - Wolfson is the hospital of choice for children. They prefer Baptist hospitals for themselves, partly because they are employed there, and partly due to proximity
 - They do not go to the ER for non-emergency issues, except one respondent who said they know someone who does because they do not have insurance
- 6. Are there health services you need that are not available to you?**
- There are resources out there, but not everybody knows about them. Suggested that a guide be compiled
 - If you have insurance, your needs are almost always met. But without insurance, it is hard to get services
 - Cost of medications, even with private insurance, can strain someone's finances
 - It is difficult to take care of a special needs child. Providing everything they need is hard
 - Dental services.
 - Prescriptions are so expensive that you have to choose which ones to take or even choose not to take any at all
 - There is not any specialist care for those who do not have insurance
 - Many groups said that they feel everything they need is covered
- 7. Have you personally ever experienced any trouble with doctors accepting Medicaid or self-pay (uninsured)?**
- Medicaid coverage doesn't include many doctors
 - Yes; many people with disabled children have applied for Medicaid and can't get it
 - They were told that the hospital would help them pay their bills, but they never did, causing their credit to take a hit. Additionally, if you do not have insurance, you must wait much longer than insured people to see a doctor, which often times turns a minor issue into a major one
 - Not personally, but they know that Mayo has a reputation for practices that discourage Medicaid patients (i.e., charging up front and making reimbursement difficult)
- 8. How do you or your neighbors pay for health care services?**
- Variety of answers (e.g., employer-provided private insurance, out-of-pocket, HAS, Medicaid and Medicare)
 - Respondents acknowledged that people with insurance are more likely to go to the doctor and only go to the emergency room if they really had to go
 - Some expenses covered, then out-of-pocket
 - They don't think having insurance would make someone go to their family doctor or ER more

BAPTIST HEALTH – SUMMARY AND CONCLUSIONS**9. How has the local economy affected you or your neighbors' health?**

- Behavioral health has suffered, due to increased stress levels
- Don't tend to issues until they are life-threatening
- Things cost more, but wages are not increasing. You start having to choose which medicines to buy
- There is less work, which means less money and access to insurance
- The economy has resulted in a loss of funding, so the prices for things like vaccinations from the Health Department have gone up
- Co-pays and the cost of prescriptions have increased
- It has affected many baby-boomers because Medicare and Medicaid are getting cut

10. Think about you, your neighbors, friends and family members in your community. What prevents you from taking care of yourselves (or staying healthy)?

- Money (affording healthy food, cost of medication) Education about how to live healthy on a budget would be helpful
- Transportation, both individual and public. Gas prices are high for those with cars and public transportation is not very user-friendly
- Access to good food is a problem (food desert)
- Not everyone is educated on nutrition
- Lack of insurance
- Time management issues – work is time-consuming
- Self-motivation/laziness

11. Again, thinking about you, your neighbors, friends and family members. What influences your decisions to take care of your health?

- Seeing/taking care of sick relatives
- Wanting to be around for their children
- Being a role model for their children
- Advice from doctors
- Monetary incentives for healthy lifestyles from insurance
- Children, doctors and church members all encourage healthy choices
- Healthy peer pressure from co-workers at the hospital.
- Independence and the ability to take care of yourself

12. Is there anything else you'd like to tell us or talk about?

- Providing more activities for the kids
- Behavioral problems in children.
- They would like to see a place established where immigrants and migrant workers can go to get the help they need.
- They like the fact that Wolfson and Nemours are next to each other
- There is a lot of communication technology, but very little actual communication
- Specialty care for people without a lot of money is a big issue. Community meetings (such as the focus groups) are very valuable.

JACKSONVILLE METROPOLITAN COMMUNITY BENEFIT PARTNERSHIP
ST. VINCENT'S HEALTHCARE — SUMMARY AND CONCLUSIONS

1. **What do people in your community do to stay healthy?**
 - Come to the clinic
 - Eat well
 - Exercise (e.g., going to the gym, walking, biking, in-home gym)
 - Health information comes from many different places (e.g., television, advertisements, other people)
 - They would like the school playgrounds and tracks to be open more so that they don't have to drive all the way to the park
2. **Is this a good place to raise children? (only ask parent groups)**
 - N/A
3. **Do you feel there is economic opportunity in the community?**
 - There are not economic opportunities for locally owned businesses
 - There is not an opportunity for on-the-job training. Most employers want someone with prior experience, but aren't willing to train, so getting hired is difficult
 - There are some educational opportunities, if you have the qualifications i.e. high school diploma or GED
 - Some do not feel there is affordable housing and others have experienced the opposite
4. **Do you feel your community is a safe place to live?**
 - Overall, yes They feel safe at home, at work, at schools, playgrounds and parks (Clay County)
 - The older children make it unsafe for young children at the park
 - No, only if you have a gun Don't feel safe living alone (Putnam County)
 - Schools are safe
 - Neighbors do look out for each other. They feel they have to in the rough environment
5. **Where do you or most of your neighbors go for health care services?**
 - Way Free Clinic.
 - Primary care physician
 - There was debate over using emergency rooms for non-emergency issues. Some argue that it isn't right and others argue that it's their only choice under special circumstances (no insurance/money, odd hours of the day)
 - Family medical and Gainesville/Shands for emergency room care They do not use the emergency room for non-emergency care (Putnam County)
6. **Are there health services you need that are not available to you?**
 - Dental and optical services.
 - Women's health services (mammogram, pap smear)
 - Behavioral health/substance abuse.
 - Prescription medication assistance
7. **Have you personally ever experienced any trouble with doctors accepting Medicaid or self-pay (uninsured)?**
 - Yes. A couple of people had issues getting an interpreter for a deaf child.
 - It is hit or miss Some places turn down self-pay because patients were trying to get pain pills from multiple doctors

ST. VINCENT'S HEALTHCARE — SUMMARY AND CONCLUSIONS

8. How do you or your neighbors pay for health care services?

- Most respondents don't have insurance and pay when they can.
- They speculate that their neighbors get insurance through their employers
- Social Security and Medicare (Putnam County)

9. How has the local economy affected you or your neighbors' health?

- People have high blood pressure and heart trouble from the stress
- Many people have lost their insurance or are living on wages that do not allow them to buy insurance

10. Think about you, your neighbors, friends and family members in your community. What prevents you from taking care of yourselves (or staying healthy)?

- Money and insurance You can exercise all you want but if you get sick, you're out of luck
- The cost of medicine.
- Transportation.
- Stress
- Cost of healthy foods

11. Again, thinking about you, your neighbors, friends and family members. What influences your decisions to take care of your health?

- Family (i.e., children and grandchildren, parents, spouses)
- "Myself" Individual motivation to stay healthy
- Neighbors
- Doctors

12. Is there anything else you'd like to tell us or talk about?

- Respondents suggested more readily available information about free and low-cost services
- Also suggested a mobile dental service
- They would like to have a place that they can make a payment plan with a doctor

CONCLUSIONS

- Many people exercise by walking and biking. More may bike if they felt like the infrastructure supported it
- Health information comes from a variety of places, mainly television, Internet and doctors.
- Overall, respondents did not feel like there was economic opportunity in any of the four areas they were asked about
- Respondents from Clay County felt safe but those in Putnam County did not feel safe at all. They even mentioned that they only feel safe with a gun
- Most respondents have primary care physicians and only go to the emergency room when absolutely necessary
- Dental services were mentioned across the board. Behavioral health was a concern as well
- Most respondents don't have insurance, so they pay when they can
- The economy has resulted in lost wages and insurance. This has led to a spike in stress levels. The lack of money for health services/healthy foods and stress levels are negatively affecting people's health
- People are motivated by those around them, most frequently children and grandchildren, as they want to be around to see them grow up



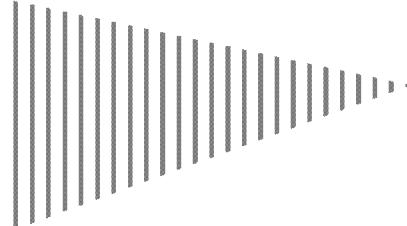
HEALTH PLANNING
COUNCIL
OF NORTHEAST FLORIDA

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CONSOLIDATED FINANCIAL STATEMENTS AND
SUPPLEMENTARY INFORMATION

Baptist Health System, Inc and Subsidiaries
Years Ended September 30, 2014 and 2013
With Report of Independent Certified Public Accountants

Ernst & Young LLP



Baptist Health System, Inc. and Subsidiaries

Consolidated Financial Statements and
Supplementary Information

Years Ended September 30, 2014 and 2013

Contents

Report of Independent Certified Public Accountants	1
Consolidated Financial Statements	
Consolidated Balance Sheets	3
Consolidated Statements of Operations and Changes in Net Assets	4
Consolidated Statements of Cash Flows	6
Notes to Consolidated Financial Statements	8
Supplementary Information	
Consolidating Balance Sheet, September 30, 2014	48
Consolidating Statement of Operations and Changes in Net Assets, Year Ended September 30, 2014	52
Consolidating Balance Sheet, September 30, 2013	56
Consolidating Statement of Operations and Changes in Net Assets, Year Ended September 30, 2013	60

Report of Independent Certified Public Accountants

The Board of Directors
Baptist Health System, Inc and Subsidiaries

We have audited the accompanying consolidated financial statements of Baptist Health System, Inc and Subsidiaries, which comprise the consolidated balance sheets as of September 30, 2014 and 2013, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in conformity with U.S. generally accepted accounting principles, this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free of material misstatement, whether due to fraud or error

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Baptist Health System, Inc and Subsidiaries at September 30, 2014 and 2013, and the consolidated results of their operations and their cash flows for the years then ended in conformity with U S generally accepted accounting principles

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating detail on pages 48 through 63 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Ernst & Young LLP

January 26, 2015

Baptist Health System, Inc. and Subsidiaries

Consolidated Balance Sheets

(In Thousands)

	September 30	
	2014	2013
Assets		
Current assets		
Cash and cash equivalents	\$ 96,283	\$ 103,476
Accounts receivable, less estimated uncollectible accounts of \$89,142 in 2014 and \$81,306 in 2013	196,696	159,531
Inventories	21,637	19,278
Prepaid expenses and other current assets	26,533	20,414
Current portion of assets limited as to use	11,094	9,215
Total current assets	<u>352,243</u>	<u>311,914</u>
Assets limited as to use		
Internally designated for capital improvements, debt service and insurance reserves	1,077,160	919,072
Less amounts required to meet current obligations	11,094	9,215
	<u>1,066,066</u>	<u>909,857</u>
Property, plant, and equipment, net	852,787	853,353
Investments	71,702	59,401
Other assets	103,060	87,489
Total assets	<u>\$ 2,445,858</u>	<u>\$ 2,222,014</u>
Liabilities and net assets		
Current liabilities		
Current portion of long-term debt	\$ 23,493	\$ 23,751
Accounts payable and accrued liabilities	159,234	123,567
Estimated third-party settlements	4,174	5,739
Total current liabilities	<u>186,901</u>	<u>153,057</u>
Long-term debt, net of current portion	510,541	534,116
Other liabilities	196,103	142,225
Total liabilities	<u>893,545</u>	<u>829,398</u>
Net assets		
Unrestricted	1,482,970	1,342,132
Temporarily restricted	30,831	26,491
Permanently restricted	38,512	23,993
Total net assets	<u>1,552,313</u>	<u>1,392,616</u>
Total liabilities and net assets	<u>\$ 2,445,858</u>	<u>\$ 2,222,014</u>

See accompanying notes

Baptist Health System, Inc. and Subsidiaries

Consolidated Statements of Operations and Changes in Net Assets (In Thousands)

	Year Ended September 30	
	2014	2013
Unrestricted revenues and other support		
Patient service revenues	\$ 1,366,092	\$ 1,307,654
Provision for bad debts	(77,967)	(124,468)
Net patient service revenues less provision for bad debts	<u>1,288,125</u>	<u>1,183,186</u>
Other revenues	57,731	57,128
Net assets released from restrictions used for operations	4,098	3,748
Total unrestricted revenues and other support	<u>1,349,954</u>	<u>1,244,062</u>
Operating expenses		
Salaries and benefits	684,400	660,991
Professional fees	39,380	33,283
Supplies	245,237	226,701
Interest	8,557	9,026
Depreciation and amortization	84,649	77,774
Other expenses	182,990	154,968
Total operating expenses	<u>1,245,213</u>	<u>1,162,743</u>
Income from operations	104,741	81,319
Nonoperating gains		
Investment income	80,010	74,829
Other, net	6,688	8,935
Total nonoperating gains	<u>86,698</u>	<u>83,764</u>
Excess of revenues and gains over expenses	191,439	165,083

Continued on next page

Baptist Health System, Inc. and Subsidiaries

Consolidated Statements of Operations and Changes in Net Assets (continued) (In Thousands)

	Year Ended September 30	
	2014	2013
Unrestricted net assets		
Excess of revenues and gains over expenses	\$ 191,439	\$ 165,083
Other changes in unrestricted net assets		
Changes related to pension and executive compensation other than period costs	(45,905)	95,629
Contributions for the purchase of property, plant, and equipment	54	158
Transfers to temporarily restricted net assets	(9)	-
Net assets released from restrictions used for the purchase of property, plant, and equipment	2,613	5,434
Unrealized (loss) gain on interest rate swap agreements	(74)	1,627
Other, including net asset transfers from BHS to BHSF for endowment matching program	(7,280)	(571)
Increase in unrestricted net assets	<u>140,838</u>	267,360
Temporarily restricted net assets		
Restricted contributions	7,322	6,990
Investment gain	792	847
Transfer from unrestricted net assets	9	-
Transfer of investment gains from permanently restricted net assets	2,923	2,861
Net assets released from restrictions	(6,711)	(9,182)
Net asset transfers from BHS to BHSF	5	(4)
Increase in temporarily restricted net assets	<u>4,340</u>	1,512
Permanently restricted net assets		
Contributions	8,199	10,671
Investment gain	2,923	2,861
Transfer of investment gains to temporarily restricted net assets	(2,923)	(2,861)
Net asset transfers from BHS to BHSF for endowment matching program	6,320	-
Increase in permanently restricted net assets	<u>14,519</u>	10,671
Increase in net assets	159,697	279,543
Net assets, beginning of year	<u>1,392,616</u>	1,113,073
Net assets, end of year	<u>\$ 1,552,313</u>	\$ 1,392,616

See accompanying notes

Baptist Health System, Inc. and Subsidiaries

Consolidated Statements of Cash Flows

(In Thousands)

	Year Ended September 30	
	2014	2013
Operating activities		
Change in net assets	\$ 159,697	\$ 279,543
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	84,649	77,774
Interest, dividends, and net gains on investments	(80,010)	(74,829)
Change in fair value of interest rate swaps	(2,005)	(10,325)
Changes related to pension and executive compensation other than period costs	45,905	(95,629)
Provision for bad debts	77,967	124,468
Loss on sale of equipment	21	20
Contributions for the purchase of property, plant, and equipment	(54)	(158)
Restricted contributions and investment income received	(19,236)	(21,369)
Increase in accounts receivable	(115,132)	(116,326)
Increase in inventories and other current assets	(8,478)	(4,044)
Increase in accounts payable and accrued liabilities	35,667	4,830
Decrease in estimated third-party settlements	(1,565)	(686)
Decrease in other liabilities	(3,932)	(15,496)
Net cash provided by operating activities	173,494	147,773
Investing activities		
Proceeds from sales and maturities of assets limited to use classified as trading	235,102	192,767
Purchases of assets limited to use classified as trading	(315,102)	(167,767)
Proceeds from sales and maturities of investments classified as trading	10,016	21,811
Purchases of investments classified as trading	(16,987)	(34,783)
Purchases of property, plant, and equipment	(81,342)	(126,985)
Increase in other assets	(7,914)	(11,562)
Net cash used in investing activities	(176,227)	(126,519)

Continued on next page

Baptist Health System, Inc. and Subsidiaries

Consolidated Statements of Cash Flows (continued)
(*In Thousands*)

	Year Ended September 30	
	2014	2013
Financing activities		
Issuance of long-term debt	\$ —	\$ 14,000
Repayments of long-term debt	(23,750)	(23,039)
Contributions for the purchase of property, plant, and equipment	54	158
Restricted contributions and investment income received	19,236	21,369
Net cash (used in) provided by financing activities	<u>(4,460)</u>	<u>12,488</u>
Net (decrease) increase in cash and cash equivalents	(7,193)	33,742
Cash and cash equivalents, beginning of year	<u>103,476</u>	<u>69,734</u>
Cash and cash equivalents, end of year	<u>\$ 96,283</u>	<u>\$ 103,476</u>
Supplemental disclosure of cash flow information		
Cash paid for interest	<u>\$ 8,033</u>	<u>\$ 8,402</u>

See accompanying notes

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (*Dollars in Thousands*)

September 30, 2014

1. Organization and Mission

Baptist Health System, Inc (the Parent) is a tax-exempt parent holding company located in Jacksonville, Florida, whose primary purpose is to direct the affairs of a multi-entity health care system (BHS), which includes the following subsidiaries

- Southern Baptist Hospital of Florida, Inc (SBHF) – a tax-exempt organization that operates two acute care hospitals, Baptist Medical Center – Jacksonville (BMCJ) and Baptist Medical Center – South (BMCS), and an emergency care center, Baptist Emergency Center Clay (BECC) The two hospitals have 676 and 225 licensed beds, respectively
- Baptist Medical Center of the Beaches, Inc (BMCB) – a tax-exempt, 146-bed acute care hospital
- Baptist Medical Center of Nassau, Inc (BMCN) – a tax-exempt, 62-bed acute care hospital
- Baptist Health Properties, Inc (BHP) – a tax-exempt real estate holding company
- Baptist Health Ambulatory Services, Inc (ASI) – a tax-exempt entity that provides ancillary health care services and health screenings
- Pavilion Health Services, Inc (PHS) – a taxable entity that provides various health care and related support services such as retail pharmaceutical services, home infusion services, and primary care services
- Baptist Health System Foundation, Inc (BHSF) – a public foundation with the primary purpose of raising funds to support the activities of the tax-exempt members of BHS

SBHF, BMCB, and BMCN are collectively referred to as the Medical Centers. The Parent is the sole member or owner of each of the above affiliates and controls the multi-entity structure through appointment by the Board of Directors (the Board) and approval of all major transactions

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued) (*Dollars in Thousands*)

1. Organization and Mission (continued)

SBHF, BMCB, BMCN, BHP, and ASI comprise the Obligated Group under the terms of a Master Trust Indenture between The Bank of New York Mellon Trust Company, N A and the Obligated Group, which was issued pursuant to the Consolidated and Amended Trust Indenture dated as of December 1, 2011

Operating and Nonoperating Activities

BHS's primary mission is to meet the health care needs in the region through an integrated network of affiliated organizations BHS's affiliated organizations are committed to providing a broad range of general and specialized health care services, including inpatient primary care, outpatient services, and other health care services Activities directly associated with the furtherance of this purpose are considered operating activities Other activities that result in gains or losses unrelated to BHS's primary mission are considered nonoperating activities

Charity Care

BHS accepts patients regardless of their ability to pay A patient is classified as a charity patient in accordance with certain established policies of BHS Because BHS does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue BHS maintains records to identify and monitor the level of charity care it provides The records include the amount of charges forgone for services and supplies furnished under its charity care policy and the estimated cost incurred to provide those services and supplies BHS estimates its cost of charity care using its cost accounting system to determine the cost-to-charge ratio for charity patients The estimated cost of care provided to charity patients was \$27,918 and \$27,563 for the years ended September 30, 2014 and 2013, respectively

2. Significant Accounting Policies

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Parent, SBHF, BMB, BMCN, BHP, ASI, PHS, and BHSF Significant transactions between entities have been eliminated

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued) (*Dollars in Thousands*)

2. Significant Accounting Policies (continued)

Use of Estimates

Management has made estimates that affect the reported amounts of certain assets, liabilities, revenues, and expenses Actual results could differ from those estimates

Cash and Cash Equivalents

Cash and cash equivalents include amounts deposited in operating accounts and cash invested in highly liquid instruments, with a maturity of three months or less when acquired, excluding amounts limited as to use by Board designation or other arrangements under trust agreements

Concentrations of Credit Risk

Financial instruments that potentially subject BHS to concentrations of credit risk consist principally of cash and cash equivalents and derivatives BHS invests its cash in credit instruments of highly rated financial institutions Four institutions hold 100% of the total cash and cash equivalents as of September 30, 2014 and 2013, and the derivative agreements have been entered into with five institutions as of September 30, 2014 and 2013

Assets Limited as to Use

Assets limited as to use primarily include assets held by a trustee which have been set aside by the Board for future capital improvements, debt service, and insurance reserves, over which the Board retains control and may, at its discretion, subsequently use for other purposes Amounts required to meet current malpractice and workers' compensation liabilities of BHS are reported as current assets

Investments and Investment Income

Investments are carried at fair value at the consolidated balance sheet dates Investment income (including realized gains and losses on investments) is included in nonoperating gains unless the income or loss is restricted by donor or law Unrealized gains and losses on investments are included in the excess of revenues and gains over expenses, as substantially all of BHS's investment portfolio is classified as trading

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued) (*Dollars in Thousands*)

2. Significant Accounting Policies (continued)

Property, Plant, and Equipment

Property, plant, and equipment are stated at cost or, if donated, at fair value at the date of the gift. Depreciation is determined on the straight-line method over the estimated useful lives of the related assets. As of September 30, 2014, BHS had open construction commitments totaling \$13,977 for construction projects, which are included in construction-in-progress in Note 4.

Deferred Compensation

PHS participates in the Pavilion Health Services, Inc. Nonqualified Deferred Compensation Plan (the Plan). The purpose of the Plan is to retain quality personnel by allowing them to defer compensation to a later date or upon their death or disability. The Plan assets are equal to the Plan liabilities and were \$55,126 and \$41,299 at September 30, 2014 and 2013, respectively.

Excess of Revenues and Gains over Expenses

The accompanying consolidated statements of operations and changes in net assets include excess of revenues and gains over expenses. Changes in unrestricted net assets, which are excluded from the excess of revenues and gains over expenses, consistent with industry practice, include changes related to pension and executive compensation other than period costs, unrealized gains/losses on certain interest rate swap agreements, contributions of long-lived assets including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets, and matching contributions from the Parent for the endowment matching program.

Electronic Health Record Payments

The American Recovery and Reinvestment Act of 2009 included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act (HITECH). The provisions were designed to increase the use of electronic health record (EHR) technology and establish the requirements for a Medicare and Medicaid incentive payment program beginning in 2011 for eligible providers that adopt and meaningfully use certified EHR technology. Eligibility for the annual Medicare incentive payments is dependent on providers demonstrating meaningful use of EHR technology in each period over a four-year period. Initial Medicaid incentive payments are available to providers that adopt,

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued) (*Dollars in Thousands*)

2. Significant Accounting Policies (continued)

implement, or upgrade certified EHR technology. Providers must also demonstrate meaningful use of such technology in subsequent years to qualify for additional Medicaid incentive programs. For the years ended September 30, 2014 and 2013, BHS has recorded \$441 and \$1,762, respectively, in Medicaid incentive payments and \$6,315 and \$7,431, respectively, in Medicare incentive payments in other operating revenue. BHS's attestation of compliance with the meaningful use criteria will be subject to audit by the federal government or its designee. Additionally, Medicare EHR incentive payments received are subject to retrospective adjustment upon final settlement of the applicable cost report from which payments were calculated.

Adoption of New Accounting Pronouncements

In October 2012, the FASB issued ASU 2012-05 *Not-for-Profit Entities: Classification of the Sale Proceeds of Donated Financial Assets in the Statement of Cash Flows*. ASU 2012-05 requires a not-for-profit to classify cash receipts from the sale of donated financial assets consistently with cash donations received in the statement of cash flows if those cash receipts were from the sale of donated financial assets that, upon receipt, were directed without any not-for-profit, imposed limitations for sale and were converted nearly immediately into cash. Accordingly, the cash receipts from the sale of those financial assets should be classified as cash inflows from operating activities, unless the donor restricted the use of the contributed resources to long-term purposes, in which case those cash receipts should be classified as cash flows from financing activities. Otherwise, cash receipts from the sale of donated financial assets should be classified as cash flows from investing activities. The amendments in the ASU are effective for fiscal years and interim periods within those years, beginning after June 15, 2013. BHS adopted ASU 2012-05 effective October 1, 2013. Management has determined there is no material impact of the new guidance on BHS's consolidated financial statements.

In July 2012, the FASB issued ASU 2012-02, *Testing Indefinite-Lived Intangible Assets for Impairment*. Under this guidance, an entity has the option to first assess qualitative factors to determine whether the existence of events and circumstances indicates that it is more likely than not that indefinite-lived intangible assets are impaired. If an entity concludes that it is not more likely than not that impairment has occurred, then the entity is not required to take further action. However, if an entity concludes otherwise, then it is required to determine the fair value of the indefinite-lived intangible assets and perform the quantitative impairment test in accordance with existing accounting guidance. The guidance is effective for fiscal years and interim periods.

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued) (*Dollars in Thousands*)

2. Significant Accounting Policies (continued)

beginning after December 15, 2012 BHS adopted ASU 2012-02 effective October 1, 2013 As a result of adopting this standard, management performed a qualitative assessment and determined it is not more likely that not an impairment has occurred, thus, requiring no further action

In December 2011, the FASB issued ASU 2011-11, *Disclosures about Offsetting Assets and Liabilities*. Offsetting (netting) assets and liabilities is an important aspect of presentation in financial statements The differences in offsetting requirements of U S generally accepted accounting principles (GAAP) compared to International Financial Reporting Standards (IFRS) account for significant differences in the amounts presented in statements of financial position as reported under each set of accounting requirements These differences reduce the comparability of statements of financial position ASU 2011-11 requires disclosure about offsetting and related arrangements to enable financial statement users to understand the effect of those arrangements on financial position In January 2013, the FASB issued ASU 2013-01, *Clarifying the Scope of Disclosures about Offsetting Assets and Liabilities*. The amendments in ASU 2013-01 and 2011-11 are effective for fiscal years beginning on or after January 1, 2013, and interim periods within those annual periods BHS adopted ASU 2013-01 and 2011-11 effective October 1, 2013 Management has determined there is no material impact of the new guidance on BHS's consolidated financial statements

Prospective Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board ("FASB"), in conjunction with the International Accounting Standards Board, issued Accounting Standards Update ("ASU") No 2014-09, *Revenue from Contracts with Customers* The objective of this ASU is to significantly enhance comparability and clarify principles of revenue recognition practices across entities, industries, jurisdictions, and capital markets For a not-for-profit entity that has issued, or is a conduit bond obligor for, securities that are traded, listed, or quoted on an exchange or an over-the-counter market, the amendments in this ASU are effective for annual reporting periods beginning after December 15, 2016, including interim reporting periods within that reporting period Early application is not permitted The standard can be adopted either retrospectively to each prior reporting period presented or as a cumulative effect adjustment as of the date of adoption BHS is currently evaluating the impact of adopting this new guidance on its financial position and results of operations and will adopt the provisions of this statement in fiscal 2018

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued) (*Dollars in Thousands*)

2. Significant Accounting Policies (continued)

Net Patient Service Revenues, Accounts Receivable, and Provision for Bad Debts

Patient service revenues are reported at estimated net realizable amounts for services rendered. BHS recognizes patient service revenues associated with patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, revenue is recognized on the basis of discounted rates in accordance with BHS' policy.

Patient service revenues are reduced by the provision for bad debts and accounts receivable are reduced by an allowance for uncollectible accounts. These amounts are based on management's assessment of historical and expected net collections for each major payor source, considering business and economic conditions, trends in health care coverage and other collection indicators. Management regularly reviews collections data by major payor sources in evaluating the sufficiency of the allowance for uncollectible accounts. On the basis of historical experience, a significant portion of BHS' self-pay patients will be unable or unwilling to pay for the services provided. Thus, BHS records a significant provision for bad debts in the period services are provided related to self-pay patients. For receivables associated with patients who have third-party coverage, BHS analyzes contractually due amounts and provides an allowance for uncollectible accounts and a provision for bad debts, if necessary. Accounts receivable are written off after collection efforts have been followed in accordance with BHS' policies.

For all patients other than charity patients, patient service revenues, net of contractual allowances and self-pay discounts and before the provision for bad debts, recognized from major payor sources is as follows:

	Year Ended September 30	
	2014	2013
Third-party payors, net of contracted adjustments	\$ 1,309,414	\$ 1,240,842
Self-pay patients, net of discounts	56,678	66,812
	\$ 1,366,092	\$ 1,307,654

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued) (*Dollars in Thousands*)

2. Significant Accounting Policies (continued)

BHS has determined, based on an assessment at the reporting-entity level, that patient service revenues are primarily recorded prior to assessing the patient's ability to pay and as such, the entire provision for bad debts is recorded as a deduction from patient service revenues in the accompanying consolidated statements of operations and changes in net assets

Significant concentrations of patient accounts receivable, after bad debt, due from payors at September 30, 2014 and 2013, respectively, include 22% and 22% from the Medicare program, 13% and 9% from state Medicaid programs, 58% and 60% in each year from contracts with other third parties, and 7% and 9% from self-pay patients BHS grants credit without collateral to their patients, most of who are local residents and are insured under third-party payor agreements

During the years ended September 30, 2014 and 2013, respectively, approximately 24% and 24% of net patient service revenues were received under the Medicare program, 9% and 7% under state Medicaid programs, 63% and 64% from contracts with other third parties, and 4% and 5% from self-pay patients In addition, \$501,808 and \$462,812 of net patient service revenues were derived from two third-party payors during the years ended September 30, 2014 and 2013, respectively

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term Changes in the Medicare and Medicaid programs and the reduction of funding levels could have an adverse impact on BHS

BHS is subject to retroactive revenue adjustments due to future audits, reviews and investigations Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered, and such amounts are adjusted in future periods as adjustments become known or as years are no longer subject to such audits, reviews and investigations During the years ended September 30, 2014 and 2013, net patient service revenues increased by \$7,718 and \$4,820, respectively, due to changes in estimated prior year settlements

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued) (*Dollars in Thousands*)

2. Significant Accounting Policies (continued)

Trade Receivables

Trade accounts receivable have both a contractual maturity of one year or less and arise from the sale of goods or services. Accounts are reviewed monthly and deemed uncollectible after 365 days and subsequently written off.

Functional Expenses

BHS does not present expense information by functional classification because its resources and activities are primarily related to providing health care services. Further, since BHS receives substantially all of its resources from providing health care services in a manner similar to a business enterprise, other indicators contained in these consolidated financial statements are considered important in evaluating how well management has discharged its stewardship responsibilities.

Inventories

Inventories are stated at lower of cost (principally determined by the weighted-average method) or market.

Income Taxes

The Parent, SBHF, BMCB, BMCN, BHP, ASI, and BHSF are not-for-profit corporations and are exempt from federal income taxes under Section 501(a) as organizations described in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, and are exempt from state income taxes pursuant to Florida Statute Chapter 220. PHS is a taxable corporation and files federal, Florida, and Georgia income tax returns. Tax-related interest and penalties are included in other expense on the accompanying consolidated statements of operations and changes in net assets. Income taxes related to PHS are not material to BHS.

With respect to its for-profit entity as well as any unrelated business income generated at the tax-exempt entities, BHS records income taxes using the liability method, under which deferred tax assets and liabilities are determined based on the differences between the financial accounting and tax bases of assets and liabilities. Deferred tax assets or liabilities at the end of each period are determined using the currently enacted tax rate expected to apply to taxable income in the period that the deferred tax asset or liability is expected to be realized or to be settled.

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued) (*Dollars in Thousands*)

2. Significant Accounting Policies (continued)

Loan Issue Costs

The costs incurred in connection with the issuance of the various Hospital Revenue Bonds (see Note 7) are being amortized over the term of the related indebtedness on the effective interest method

Goodwill and Other Intangible Assets

Goodwill and other intangible assets, included in other assets, consist principally of cost in excess of the net book value of purchased businesses, internally developed software, medical records, and purchased provider contracts and treatment protocols Goodwill is not amortized but is reviewed annually for impairment or more frequently if impairment indicators arise If such indicators are present, BHS uses projections of future discounted cash flows and other procedures to determine whether the entity's estimated fair value is less than its carrying amount, and, if so, BHS recognizes an impairment loss based on the excess of the carrying amount of the goodwill over its fair value Intangible assets with a finite useful life are amortized on a straight-line basis over their useful life Intangible assets with an indefinite life are tested annually for impairment

Donor-Restricted Gifts

Donor-restricted gifts and endowments are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets or are subject to time restrictions BHSF's policy provides for the establishment of endowments by donors who wish to provide a permanent source of funding for equipment, operations, and charity care at BHS affiliates The policy provides for investment of endowment gifts by the Foundation for long-term growth of the endowment and limits the amount to be disbursed annually from these investment earnings When a donor restriction expires (that is, when a stipulated time restriction ends or purpose restriction is accomplished) temporarily restricted net assets are reclassified as unrestricted net assets and reported in the accompanying statements of activities as released from restrictions Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying financial statements

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued) (*Dollars in Thousands*)

2. Significant Accounting Policies (continued)

BHS participates in an endowment matching program in which they match donor contributions to endowments on a tiered basis. Of the net assets transferred, the matching contributions transferred from BHS unrestricted net assets to Foundation restricted net assets for the years ending September 30, 2014 and 2013 are \$6,320 and \$0, respectively. The amounts transferred by BHS for matching contributions are permanently restricted net assets as required to match external donor amounts as outlined in the donors' contribution agreements.

Temporarily Restricted Net Assets

Temporarily restricted net assets are primarily available for operations and to purchase equipment, renovations, and buildings. Temporarily restricted net assets are available for the following purposes or periods

	September 30	
	2014	2013
Hospital programs	\$ 16,331	\$ 12,793
Education and research	5,491	4,869
Property and equipment	4,796	5,204
Community Outreach	3,095	2,528
Other program services	1,074	1,053
Future time periods	44	44
	\$ 30,831	\$ 26,491

Permanently Restricted Net Assets

Permanently restricted net assets are those preserved by donor intent to provide a permanent source of investment income for the operations of the Medical Centers' adult and children's hospital divisions. Permanently restricted net assets are restricted to

	September 30	
	2014	2013
Hospital programs	\$ 32,429	\$ 20,870
Education and research	3,581	1,074
Community outreach	1,841	1,629
Other program services	552	420
Property and equipment	109	—
	\$ 38,512	\$ 23,993

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued) (*Dollars in Thousands*)

2. Significant Accounting Policies (continued)

Reclassifications

Certain reclassifications have been made to the 2013 financial statements to be consistent with the 2014 presentation. These reclassifications had no effect on net assets previously reported.

3. Investments and Assets Limited as to Use

Assets Limited as to Use

The composition of assets limited as to use is presented below.

	September 30	
	2014	2013
Internally designated for capital improvements, debt service, and insurance reserves		
Equity mutual funds		
Domestic	\$ 408,032	\$ 320,341
International	146,630	127,083
Fixed-income mutual funds		
Domestic	491,546	443,874
International	30,457	27,116
Interest receivable	495	658
	\$ 1,077,160	\$ 919,072

Investment return is summarized as follows.

	Year End September 30	
	2014	2013
Interest, dividends, and realized gains	\$ 43,714	\$ 43,335
Net unrealized gains on investments reported at fair value	40,011	35,202
Total investment return	\$ 83,725	\$ 78,537
Included in nonoperating gains	\$ 80,010	\$ 74,829
Reported separately as increase in restricted net assets	3,715	3,708
Total investment return	\$ 83,725	\$ 78,537

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

3. Investments and Assets Limited as to Use (continued)

The amount of net unrealized gains for investments and assets limited as to use still held as of September 30, 2014, is \$156,211

Investments

Investments include the following

	September 30	
	2014	2013
Equity securities	\$ 182	149
Equity mutual funds		
Domestic	29,513	22,590
International	11,425	9,611
Fixed-income mutual funds		
Domestic	20,833	17,637
International	2,380	2,056
Cash and cash equivalents	7,319	7,292
Interest receivable	50	66
	\$ 71,702	\$ 59,401

4. Property, Plant, and Equipment

BHS had property, plant, and equipment less accumulated depreciation as follows

	September 30	
	2014	2013
Land and improvements	\$ 56,296	\$ 54,566
Building and equipment	1,639,567	1,577,767
	1,695,863	1,632,333
Less accumulated depreciation	(881,459)	(801,440)
	814,404	830,893
Construction-in-progress	38,383	22,460
	\$ 852,787	\$ 853,353

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

5. Other Assets

Other assets consist of the following

	September 30	
	2014	2013
Long-term pledge receivables	\$ 7,201	\$ 5,714
Goodwill and intangible assets	13,052	15,553
Equity investment in Solantic	18,466	19,159
Deferred compensation	55,126	41,299
Beneficial interest in trust held by others	719	364
Other	8,496	5,400
	<u>\$ 103,060</u>	<u>\$ 87,489</u>

6. Goodwill and Other Intangible Assets

BHS's intangible assets are summarized as follows

	September 30, 2014		
	Gross	Accumulated Amortization	Net
Intangible assets subject to amortization			
Internally developed software	\$ 10,127	\$ (4,161)	\$ 5,966
Medical records	2,452	(1,454)	998
Noncompete agreements	1,667	(1,667)	—
Other	3,406	(2,470)	936
Intangible assets not subject to amortization (indefinite life)			
Goodwill	3,674	—	3,674
Other	1,400	—	1,400
Trade name	78	—	78
	<u>\$ 22,804</u>	<u>\$ (9,752)</u>	<u>\$ 13,052</u>

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

6. Goodwill and Other Intangible Assets (continued)

	September 30, 2013		
	Gross	Accumulated Amortization	Net
Intangible assets subject to amortization			
Internally developed software	\$ 10,127	\$ (2,714)	\$ 7,413
Medical records	2,356	(1,003)	1,353
Noncompete agreements	1,667	(1,667)	—
Other	3,406	(1,771)	1,635
Intangible assets not subject to amortization (indefinite life)			
Goodwill	3,674	—	3,674
Other	1,400	—	1,400
Trade name	78	—	78
	\$ 22,708	\$ (7,155)	\$ 15,553

Amortization expense related to computer software costs was \$1,447 and \$1,469 for the years ended September 30, 2014 and 2013, respectively. Total amortization expense related to intangible assets was \$2,597 and \$2,607 for the years ended September 30, 2014 and 2013, respectively. Expected amortization expense for the next five years is as follows:

2015	\$ 2,598
2016	2,015
2017	1,580
2018	1,207
2019	459
Thereafter	41
	\$ 7,900

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(*Dollars in Thousands*)

6. Goodwill and Other Intangible Assets (continued)

The changes in the carrying amount of goodwill are as follows

	Year Ended September 30	
	2014	2013
Goodwill balance, beginning of period	\$ 3,674	\$ 3,674
Goodwill acquired during the year	—	—
Goodwill adjusted during the year	—	—
Goodwill impaired during the year	—	—
Goodwill balance, end of period	\$ 3,674	\$ 3,674

7. Long-Term Debt

The Medical Centers, BHP, and ASI comprise an Obligated Group and have certain joint and several liabilities under a Master Trust Indenture to make all payments required with respect to obligations under the Master Trust Indenture, which totaled \$534,034 at September 30, 2014. The Master Trust Indenture requires certain covenants and reporting requirements to be met by the Obligated Group.

The Series 2003A, Series 2004, and Series 2007C bank held variable-rate extendable notes bear interest at a variable index interest rate of 67% of the 30-day London Interbank Offered Rate (LIBOR), plus 68 basis points. The initial interest rate period expires December 1, 2016, at which time the Series 2003A, Series 2004, and Series 2007C notes may operate in another bank purchase mode or be subject to mandatory tender for purchase. Upon mandatory tender for purchase, the Obligated Group may convert to another available interest rate mode. Interest is payable quarterly.

During March 2012, May 2012, August 2012, and December 2012, the Obligated Group issued \$60,000, \$16,000, \$10,000, and \$14,000, respectively, of Jacksonville Health Facilities Authority Hospital Revenue Extendable Notes, Series 2012A, 2012B, 2012C, and 2012D (collectively, the Series 2012 Notes). The proceeds of the Series 2012 Notes were used to finance capital expenditures for planning, developing, constructing, and equipping SBHF and BMBB. Principal payments of the Series 2012 Notes are due in varying amounts from August 15, 2014 to August 15, 2037.

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued) (*Dollars in Thousands*)

7. Long-Term Debt (continued)

The Series 2001 and Series 2007D bank held variable rate extendable notes bear interest at a variable index interest rate of 70% of 30 day LIBOR, plus 75-basis points. The margin for calculating the interest rate can change depending on the Obligated Group's credit rating. The initial interest rate period expires July 1, 2017, at which time Series 2001 and Series 2007D notes may operate in another bank purchase mode or be subject to mandatory tender for purchase. Upon mandatory tender for purchase, the Obligated Group may convert to another available interest rate mode. Interest is payable monthly.

The Series 2003C bank held fixed rate extendable note bears interest at a fixed bank rate of 1.99%. The initial interest rate period expires August 15, 2019, at which time the Series 2003C note may operate in another bank purchase mode or be subject to mandatory tender for purchase. Upon mandatory tender for purchase, the Obligated Group may convert to another available interest rate mode. Interest is payable monthly.

The Series 2003B bank held variable rate extendable note bears interest at a variable index interest rate of 74% of 30-day LIBOR, plus 75.25 basis points. The initial interest rate period expires September 4, 2017, at which time the Series 2003B note may operate in another bank purchase mode or be subject to mandatory tender for purchase. Upon mandatory tender for purchase, the Obligated Group may convert to another available interest rate mode. Interest is payable monthly.

The Series 2007B and Series 2007E bank held variable rate extendable notes bear interest at a variable index interest rate of 75% of 30-day LIBOR, plus 82 basis points. The initial interest rate period expires September 4, 2019, at which time Series 2007B and Series 2007E notes may operate in bank purchase mode or be subject to mandatory tender for purchase. Upon mandatory tender for purchase, the Obligated Group may convert to another available interest rate mode. Interest is payable monthly.

During June 2010, November 2010, and December 2010, the Obligated Group issued \$54,000, \$7,000, and \$14,000, respectively, of Jacksonville Health Facilities Authority Hospital Revenue Extendable Notes, Series 2010A, 2010B, and 2010C (collectively, the Series 2010 Notes). The proceeds of the Series 2010 Notes were used to finance capital expenditures for planning, developing, constructing, and equipping SBHF and BMB. The margin for calculating the interest rate for Series 2010C can change based on the Obligated Group's credit rating. Principal payments of the Series 2010 Notes are due in varying amounts from August 15, 2013 to August 15, 2035.

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued) (*Dollars in Thousands*)

7. Long-Term Debt (continued)

Subsequent to the fiscal year end, on October 17, 2014 the Obligated Group extended the mandatory tender dates of the Series 2010A and Series 2010C. The mandatory tender date for Series 2010A was extended to September 30, 2017 and bears interest at a variable index interest rate of 65.01% of 30 day LIBOR, plus 81 basis points. The mandatory tender date for Series 2010C was extended to June 24, 2017 and bears interest at a variable index interest rate of 65.01% of 30 day LIBOR, plus 72.5 basis points. For Series 2010C, the margin for calculating the interest rate can change depending on the borrower's debt rating.

Subsequent to the fiscal year end, on October 15, 2014, the Obligated Group amended and restated Hospital Revenue Note, Series 2009. The Series 2009 note bears interest at a variable index interest rate of 65% of 30 day LIBOR, plus 157 basis points. Principal payments of the Series 2009 note are due in varying amounts from November 2, 2009 to October 2, 2016. Interest is payable monthly.

During fiscal 2012, the Obligated Group entered into interest rate swap agreements (Series 2012A and 2012B swaps), which expire on August 15, 2022 and August 15, 2019, respectively. The Obligated Group agreed to exchange, effective March 26, 2012, and March 29, 2012, the receipt of a variable interest rate payment for the payment of a fixed interest rate payment. The fixed rates for the Series 2012A and Series 2012B swaps are 2.50% and 2.25%, respectively. The variable rate payment is based on a percentage of LIBOR, which is reset monthly. The variable and fixed payments are calculated on a combined notional amount. The Series 2012A swaps had a notional amount as of September 30, 2014 and 2013, of \$22,800 and \$23,600, respectively. The Series 2012B swaps had a notional amount as of September 30, 2014 and 2013, of \$18,300 and \$18,900, respectively. The differential to be paid or received is accrued as the variable interest rate changes and is recognized in interest expense. The related amount payable to or receivable from the counterparty is included in other liabilities or other assets, respectively. The Obligated Group recognizes the change in the fair value of the agreements within unrestricted net assets, as the agreements have been designated as effective hedges under ASC 815, *Derivatives and Hedging*. Included in unrestricted net assets are the unrealized gains/losses on the Series 2012A and Series 2012B interest rate swap agreements. The Series 2012A had an unrealized loss of \$117 for the year ended September 30, 2014 and an unrealized gain of \$1,040 for the year ended September 30, 2013. The Series 2012B had unrealized gains of \$43 and \$587 for the years ended September 30, 2014 and 2013, respectively.

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued) (*Dollars in Thousands*)

7. Long-Term Debt (continued)

The fair value of the Series 2012A swaps at September 30, 2014 and 2013, is \$(235) and \$(118), respectively. The fair value of the Series 2012B swaps at September 30, 2014 and 2013, is \$(57) and \$(100), respectively. The amounts represent the amount the Obligated Group would have to pay to the counterparty should the agreements be terminated and are included in other liabilities in the accompanying consolidated balance sheets.

During fiscal 2009, the Obligated Group entered into an interest rate swap agreement (Series 2001 swap), which expires on August 15, 2021, to convert its Series 2001 bonds from variable rate refunding debt into fixed interest rate debt. The Obligated Group agreed to exchange, effective June 11, 2009, the receipt of a variable interest rate payment for the payment of a fixed interest rate payment. The fixed rate for the Series 2001 swap is 2.75%. The variable rate payment is based on a percentage of LIBOR, which is reset weekly. The variable and fixed payments are calculated on a combined notional amount as of September 30, 2014 and 2013, of \$21,690 and \$24,370, respectively. The differential to be paid or received is accrued as the variable interest rate changes and is recognized in other expenses. The related amount payable to or receivable from the counterparty is included in other liabilities or other assets, respectively. The Obligated Group recognizes the change in the fair value of this agreement within the excess of revenues and gains over expenses, as this agreement has not been designated as an effective hedge under ASC 815. Included in nonoperating gains are \$442 and \$1,038 in unrealized gains related to the Series 2001 swap for the years ended September 30, 2014 and 2013, respectively.

The fair value of the Series 2001 swap at September 30, 2014 and 2013, is \$(1,256) and \$(1,698), respectively. The amounts represent the amount the Obligated Group would have to pay to the counterparty should the agreement be terminated and are included in other liabilities in the accompanying consolidated balance sheets.

During fiscal 2009, the Obligated Group entered into an interest rate swap agreement (Series 2007B swap), which expires on August 15, 2023, to convert its Series 2007B bonds from variable rate refunding debt to fixed interest rate debt. The Obligated Group agreed to exchange, effective June 11, 2009, the receipt of a variable interest rate payment for the payment of a fixed interest rate payment. The fixed rate for the Series 2007B swap is 2.8%. The variable rate payment is based on a percentage of LIBOR, which is reset weekly. The variable and fixed payments are calculated on a combined notional amount as of September 30, 2014 and 2013, of \$21,525 and \$23,675, respectively. The differential to be paid or received is accrued as the variable interest rate changes and is recognized in other expenses. The related amount payable to

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued) (*Dollars in Thousands*)

7. Long-Term Debt (continued)

or receivable from the counterparty is included in other liabilities or other assets, respectively. The Obligated Group recognizes the change in the fair value of this agreement within the excess of revenues and gains over expenses, as this agreement has not been designated as an effective hedge under ASC 815. Included in nonoperating gains is \$374 and \$1,128 of unrealized gains related to the Series 2007B swap for the years ended September 30, 2014 and 2013, respectively.

The fair value of the Series 2007B swap at September 30, 2014 and 2013, is \$(1,387) and \$(1,761), respectively. The amounts represent the amount the Obligated Group would have to pay to the counterparty should the agreements be terminated and are included in other liabilities in the accompanying consolidated balance sheets.

During the year ended September 30, 2006, the Obligated Group entered into forward interest rate swap agreements (Series 2007CDE swaps), which expire on August 15, 2027, to convert its Series 2007CDE bonds from variable rate refunding debt into a fixed interest rate debt. The Obligated Group agreed to exchange, effective August 15, 2007, receipt of a variable interest rate payment for the payment of a fixed interest rate payment. The fixed rate for the Series 2007CDE swaps is 3.65%. The variable rate payment is based on a percentage of LIBOR, which is reset weekly. The variable and fixed payments are calculated on a combined notional amount as of September 30, 2014 and 2013, of \$87,900 and \$93,925, respectively. The differential to be paid or received is accrued as the variable interest rate changes and is recognized in other expenses. The related amount payable to or receivable from the counterparty is included in other liabilities or other assets, respectively. The Obligated Group recognizes the change in the fair value of these agreements within the excess of revenues and gains over expenses, as these agreements have not been designated as effective hedges under ASC 815. Included in other nonoperating gains is \$1,263 and \$6,532 in unrealized gains related to the Series 2007CDE swaps for the years ended September 30, 2014 and 2013, respectively.

The fair value of the Series 2007CDE swaps at September 30, 2014 and 2013, is \$(11,835) and \$(13,098), respectively. The amounts represent the amount the Obligated Group would have to pay to the counterparty should the agreements be terminated, and are included in other liabilities in the accompanying consolidated balance sheets.

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

7. Long-Term Debt (continued)

BHS was obligated under long-term debt as follows

	September 30 2014	2013
Jacksonville Health Facilities Authority Variable Rate Hospital Revenue Extendable Notes, Series 2001, due in varying amounts from 2014 through 2021 with a variable interest rate not to exceed the maximum permitted by United States federal law or Florida law (86% and 88% as of September 30, 2014 and 2013, respectively)	\$ 21,690	\$ 24,370
Jacksonville Health Facilities Authority Variable Rate Hospital Revenue Extendable Notes, Series 2003A, due in varying amounts from 2022 through 2033 with a variable interest rate not to exceed the maximum permitted by United States federal law or Florida law (78% and 80% as of September 30, 2014 and 2013, respectively)	70,000	70,000
Jacksonville Health Facilities Authority Variable Rate Hospital Revenue Extendable Notes, Series 2003B, due in varying amounts from 2022 through 2033, with a variable interest rate not to exceed the maximum permitted by United States federal law or Florida law (87% and 89% as of September 30, 2014 and 2013, respectively)	35,000	35,000
Jacksonville Health Facilities Authority Fixed Rate Hospital Revenue Extendable Notes, Series 2003C, due in varying amounts from 2022 through 2033 (199% and 199% as of September 30, 2014 and 2013, respectively)	20,000	20,000
Jacksonville Health Facilities Authority Variable Rate Hospital Revenue Extendable Notes, Series 2004, due in varying amounts from 2020 through 2034, with a variable interest rate not to exceed 12% per annum (78% and 80% as of September 30, 2014 and 2013, respectively)	50,000	50,000

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(*Dollars in Thousands*)

7. Long-Term Debt (continued)

	September 30 2014	2013
Jacksonville Health Facilities Authority Hospital Revenue Bonds, Series 2007A, due in varying amounts from 2023 through 2037, with a fixed interest rate of 5%, including unamortized premium of \$1,145 and \$1,228 at September 30, 2014 and 2013, respectively	\$ 66,145	\$ 66,227
Jacksonville Health Facilities Authority Variable Rate Hospital Revenue Extendable Notes, Series 2007B, due in varying amounts from 2014 through 2023 with a variable interest rate not to exceed the maximum permitted by United States federal law or Florida law (94% and 96% as of September 30, 2014, and 2013, respectively)	21,525	23,675
Jacksonville Health Facilities Authority Variable Rate Hospital Revenue Refunding Extendable Notes, Series 2007C, Series 2007D and Series 2007E, due in varying amounts from 2014 through 2027 with a variable interest rate not to exceed the maximum permitted by United States federal law or Florida law (86% and 88% as of September 30, 2014 and 2013, respectively)	87,900	93,925
Jacksonville Health Facilities Authority Variable Rate Hospital Revenue Notes, Series 2009, due in varying amounts from 2014 through 2017, with a variable interest rate not to exceed the maximum permitted by United States federal law or Florida law (1 92% and 1 94% as of September 30, 2014 and 2013, respectively)	9,493	13,875
Jacksonville Health Facilities Authority Variable Rate Hospital Revenue Extendable Notes, Series 2010A, due in varying amounts from 2014 through 2035, with a variable interest rate not to exceed the maximum permitted by United States federal law or Florida law (1 07% and 1 09% as of September 30, 2014 and 2013, respectively)	22,450	23,125
Jacksonville Health Facilities Authority Variable Rate Hospital Revenue Extendable Notes, Series 2010B, due in varying amounts from 2014 through 2035, with a variable interest rate not to exceed the maximum permitted by United States federal law or Florida law (88% and 90% as of September 30, 2014 and 2013, respectively)	22,450	23,125

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

7. Long-Term Debt (continued)

	September 30 2014	2013
Jacksonville Health Facilities Authority Variable Rate Hospital Revenue Extendable Notes, Series 2010C, due in varying amounts from 2014 through 2035, with a variable interest rate not to exceed the maximum permitted by United States federal law or Florida law (90% and 92% as of September 30, 2014 and 2013, respectively)	\$ 22,450	\$ 23,125
Jacksonville Health Facilities Authority Variable Rate Hospital Revenue Extendable Notes, Series 2012A, due in varying amounts from 2014 through 2036, with a variable interest rate not to exceed the maximum permitted by United States federal law or Florida law (102% and 104% as of September 30, 2014 and 2013, respectively)	22,800	23,600
Jacksonville Health Facilities Authority Variable Rate Hospital Revenue Extendable Notes, Series 2012B, due in varying amounts from 2014 through 2036, with a variable interest rate not to exceed the maximum permitted by United States federal law or Florida law (99% and 101% as of September 30, 2014 and 2013, respectively)	18,300	18,900
Jacksonville Health Facilities Authority Variable Rate Hospital Revenue Extendable Notes, Series 2012C, due in varying amounts from 2014 through 2019, with a fixed interest rate not to exceed the maximum permitted by United States federal law or Florida law (162% and 162% as of September 30, 2014 and 2013, respectively)	9,831	11,920
Jacksonville Health Facilities Authority Variable Rate Hospital Revenue Extendable Notes, Series 2012D, due in varying amounts from 2014 through 2037, with a variable interest rate not to exceed the maximum permitted by United States federal law or Florida law (89% and 92% as of September 30, 2014 and 2013, respectively)	34,000	37,000
Less current portion	<u>534,034</u>	<u>557,867</u>
	<u>23,493</u>	<u>23,751</u>
	<u><u>\$ 510,541</u></u>	<u><u>\$ 534,116</u></u>

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

7. Long-Term Debt (continued)

The following tables outline the location and effect of the interest rate swap agreements on the accompanying consolidated balance sheets and statements of operations and changes in net assets. Fair values presented are computed using estimated future cash flows. Gains and losses on effective hedges are reported below the excess of revenue and gains over expenses.

Liability Derivatives	Balance Sheet Locations	Net Asset Classifications	Fair Value at September 30	
			2014	2013
Interest rate contracts				
Series 2001	Other liabilities	Unrestricted	\$ (1,256)	\$ (1,698)
Series 2007B	Other liabilities	Unrestricted	(1,387)	(1,761)
Series 2007CDE	Other liabilities	Unrestricted	(11,835)	(13,098)
Total derivatives not designated as hedging instruments			<u>\$ (14,478)</u>	<u>\$ (16,557)</u>
Series 2012A	Other liabilities	Unrestricted	\$ (235)	\$ (118)
Series 2012B	Other liabilities	Unrestricted	(57)	(100)
Total derivatives designated as hedging instruments			<u>\$ (292)</u>	<u>\$ (218)</u>
Total derivatives			<u><u>\$ (14,770)</u></u>	<u><u>\$ (16,775)</u></u>

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(*Dollars in Thousands*)

7. Long-Term Debt (continued)

Liability Derivatives	Location of Gain (Loss) Recognized Within Excess of Revenues Over Expenses	Amount of Gain (Loss) Recognized Within Statements of Operations and Changes in Net Assets for the Year Ended September 30	
		2014	2013
		<hr/>	
Interest rate contracts			
Series 2001	Nonoperating gains	\$ 442	\$ 1,038
Series 2007B	Nonoperating gains	374	1,128
Series 2007CDE	Nonoperating gains	<u>1,263</u>	<u>6,532</u>
Total derivatives not designated as hedging instruments		<u>\$ 2,079</u>	<u>\$ 8,698</u>
Series 2012A	Unrestricted net assets	\$ (117)	\$ 1,040
Series 2012B	Unrestricted net assets	<u>43</u>	<u>587</u>
Total derivatives designated as hedging instruments		<u>\$ (74)</u>	<u>\$ 1,627</u>
Total derivatives		<u>\$ 2,005</u>	<u>\$ 10,325</u>

A summary of the changes in the accumulated derivative loss for effective hedging transactions is as follows

	Year Ended September 30	
	2014	2013
Accumulated derivative loss, beginning of period	\$ (218)	\$ (1,845)
Net change associated with hedging transactions		
Series 2012 A	(117)	1,040
Series 2012 B	<u>43</u>	<u>587</u>
Accumulated derivative loss, end of period	<u>\$ (292)</u>	<u>\$ (218)</u>

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(*Dollars in Thousands*)

7. Long-Term Debt (continued)

Maturities of long-term debt as of September 30, 2014, are as follows

	<u>Amount</u>
Year ending September 30	
2015	\$ 23,493
2016	23,280
2017	19,723
2018	20,014
2019	19,608
Thereafter	426,771
Unamortized bond premium	1,145
	<u>\$ 534,034</u>

8. Fair Value of Financial Instruments

In accordance with ASC 820, *Fair Value Measurement*, assets and liabilities recorded at fair value in the consolidated financial statements are categorized, for disclosure purposes, based upon whether the inputs used to determine their fair values are observable or unobservable. More specifically, ASC 820 establishes a three-level fair value hierarchy that prioritizes the inputs used to measure assets and liabilities at fair value.

Level inputs, as defined by ASC 820, are as follows

Level 1 – Quoted prices (unadjusted) in active markets for identical assets or liabilities that BHS has the ability to access on the reporting date

Level 2 – Inputs other than quoted market prices included in Level 1 that are observable for the asset or liability, either directly or indirectly. If the asset or liability has a specific (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability. Level 2 assets and liabilities are valued using a market approach

Level 3 – Inputs that are unobservable for the asset or liability

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

8. Fair Value of Financial Instruments (continued)

The following tables summarize fair value measurements, by level, at September 30, 2014 and 2013, which are measured on a recurring basis in the accompanying consolidated balance sheets

	September 30, 2014			
	Level 1	Level 2	Level 3	Total
Assets				
Assets limited as to use				
Equity mutual funds				
Domestic	\$ 408,032	\$ —	\$ —	\$ 408,032
International	146,630	—	—	146,630
Fixed-income mutual funds				
Domestic	491,546	—	—	491,546
International	30,457	—	—	30,457
Long-term investments				
Equity securities	182	—	—	182
Equity mutual funds				
Domestic	29,514	—	—	29,514
International	11,425	—	—	11,425
Fixed income mutual funds				
Domestic	20,833	—	—	20,833
International	2,380	—	—	2,380
Cash and cash equivalents	7,319	—	—	7,319
Liabilities				
Interest rate swaps	—	(14,772)	—	(14,772)

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

8. Fair Value of Financial Instruments (continued)

	September 30, 2013			
	Level 1	Level 2	Level 3	Total
Assets				
Assets limited as to use				
Equity mutual funds				
Domestic	\$ 320,341	\$	–	\$ 320,341
International	127,083	–	–	127,083
Fixed-income mutual funds				
Domestic	443,874	–	–	443,874
International	27,116	–	–	27,116
Long-term investments				
Equity securities	149	–	–	149
Equity mutual funds				
Domestic	22,590	–	–	22,590
International	9,611	–	–	9,611
Fixed income mutual funds				
Domestic	17,637	–	–	17,637
International	2,056	–	–	2,056
Cash and cash equivalents	7,292	–	–	7,292
Liabilities				
Interest rate swaps	–	(16,775)	–	(16,775)

Interest Rate Swaps

The fair value of the interest rate swaps is estimated using market inputs obtained independently from third-party sources. Expected cash flows are discounted at unadjusted interbank (LIBOR) rates. The valuations represent reasonable estimates of fair values and may not represent the actual amount at which new transaction could be entered into or the actual amounts at which existing transactions could be liquidated or unwound.

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued) (*Dollars in Thousands*)

8. Fair Value of Financial Instruments (continued)

Long-Term Debt

The fair value of long-term debt is estimated based on dealer quotes for hospital tax-exempt debt with similar terms and maturities and using discounted cash flow analyses based on current interest rates for similar types of borrowing arrangements. The estimated fair value of debt using Level 2 inputs at September 30, 2014 and 2013, is \$537,082 and \$556,652, respectively.

9. Income Taxes

Deferred income taxes, which as of September 30, 2014 and 2013, have no net carrying value, reflect the net tax effect of temporary differences between the carrying amounts of assets and liabilities for financial reporting and the amounts used for income tax purposes. As of September 30, 2014 and 2013, BHS had deferred tax assets of \$24,358 and \$22,388, respectively, relating principally to net operating loss carryovers. ASC 740-10-50-3, *Income Taxes: Disclosure*, requires a valuation allowance to reduce the deferred tax assets reported if, based on the weight of the evidence, it is more likely than not that some portion or all of the deferred tax assets will not be realized. After consideration of all the evidence, both positive and negative, management determined that a \$24,358 and \$22,388 allowance at September 30, 2014 and 2013, respectively, was necessary to reduce the deferred tax assets to the amount that would more likely than not be realized. The change in the valuation allowance for the current year is \$1,970. At September 30, 2014, BHS has available net operating loss carryforwards of \$64,729. These net operating losses will expire between 2018 and 2034.

10. Retirement Plans

The Medical Centers, PHS, and ASI participate in a noncontributory defined benefit retirement plan (Retirement Plan) sponsored by BHS. The Retirement Plan covers a substantial number of the employees. Benefits are based on each participant's years of service and compensation. BHS's policy is to contribute annually at least the minimum amount necessary to comply with the requirements of the Employee Retirement Income Security Act of 1974, as amended. SBHF funds contributions to the Plan.

BHS also sponsors a supplemental executive retirement plan (SERP) and vice president supplemental executive retirement plan (VP SERP). These plans are unfunded and cover the executive management team and vice presidents of BHS. Benefits are based on each participant's years of service and compensation.

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

10. Retirement Plans (continued)

The Retirement Plan, SERP, and VP SERP are collectively referred to as the Plans

The following tables set forth the benefit obligations and the assets of the Plans, changes in the plan assets and benefit obligations recognized in unrestricted net assets, and the components of net periodic benefit costs

	September 30	
	2014	2013
Accumulated benefit obligation at end of year	\$ 469,108	\$ 380,432
Benefit obligation at beginning of year	\$ 432,035	\$ 476,413
Service cost	13,374	15,959
Interest cost	21,517	19,648
Actuarial (gain) loss	64,076	(67,132)
Benefits paid	(11,591)	(12,853)
Benefit obligation at end of year	\$ 519,411	\$ 432,035
Change in plan assets		
Fair value of plan assets at beginning of year	\$ 373,113	\$ 299,782
Actual return on plan assets	37,267	35,913
Employer contributions	27,154	50,271
Benefit payments	(11,591)	(12,853)
Fair value of plan assets at end of year	\$ 425,943	\$ 373,113
Amounts recognized in the consolidated balance sheets		
Accounts payable and accrued expenses	\$ (5,804)	\$ (337)
Other noncurrent liabilities	(87,664)	(58,585)
Deficiency of fair value of plan assets over projected benefit obligation	\$ (93,468)	\$ (58,922)

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

10. Retirement Plans (continued)

Included in unrestricted net assets at September 30, 2014 and 2013, are unrecognized prior service costs of \$42 and \$51, respectively, and unrecognized actuarial losses of \$147,888 and \$101,975, respectively, that have not yet been recognized in net periodic pension cost. The prior service cost and actuarial losses included in unrestricted net assets and expected to be recognized in net periodic pension costs during the year ending September 30, 2015, are \$9 and \$9,356, respectively.

	Year Ended September 30	
	2014	2013
Components of net periodic benefit cost		
Service cost	\$ 13,374	\$ 15,959
Interest cost	21,517	19,648
Expected return on assets	(27,160)	(24,076)
Amortization of		
Prior service cost	9	42
Actuarial loss	8,056	16,620
Amount recognized in net periodic benefit cost	\$ 15,796	\$ 28,193
Other changes in plan assets and benefit obligations recognized in unrestricted net assets		
Net actuarial (gain) loss	\$ 53,970	\$ (78,967)
Amortization of		
Prior service cost	(9)	(42)
Actuarial loss	(8,056)	(16,620)
Total recognized in unrestricted net assets	\$ 45,905	\$ (95,629)

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(*Dollars in Thousands*)

10. Retirement Plans (continued)

The assumptions used to determine accrued pension costs and net periodic pension cost are set forth below

Used to Determine Projected Benefit Obligation

	September 30	
	2014	2013
Weighted-average discount rate	4.54%	5.05%
Weighted-average rate of compensation increase	3.50	3.50
Weighted-average expected long-term rate of return on plan assets	7.50	7.50

Used to Determine Benefit Cost

	Year Ended September 30	
	2014	2013
Weighted-average discount rate	5.05%	4.17%
Weighted-average rate of compensation increase	3.50	3.50
Weighted-average expected long-term rate of return on plan assets	7.50	7.75

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(*Dollars in Thousands*)

10. Retirement Plans (continued)

Expected Cash Flows

Information about the expected cash flows for the Plans follows

Expected employer contributions in fiscal year 2015 As of September 30, 2014, no employer contributions are required in fiscal year 2015	<u>\$ 65,934</u>
Expected benefit payments	
Year ending September 30	<u>Amount</u>
2015	\$ 18,896
2016	15,755
2017	20,499
2018	23,119
2019	21,954
2020–2024	137,704

The benefit payment amounts above reflect the total benefits expected to be paid from the Plans

Asset Allocation

The weighted-average asset allocations for the Retirement Plan at the end of fiscal years 2014 and 2013, and the target allocation for fiscal 2015, by asset category, are as follows

Asset category	Target Allocation	Percentage of Plan Assets at September 30	
	2015	2014	2013
Equity securities	60%	60%	60%
Debt securities	40	40	40
Total	100%	100%	100%

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(*Dollars in Thousands*)

10. Retirement Plans (continued)

Composition of Plan Assets

The composition of the Retirement Plan's assets at September 30, 2014 and 2013, is as follows

	September 30	
	2014	2013
Fair value of plan assets		
Equity mutual funds – domestic	\$ 184,841	\$ 154,837
Equity mutual funds – international	78,167	70,158
Fixed-income mutual funds – domestic	148,766	135,036
Fixed-income mutual funds – international	13,911	12,707
Cash and short-term investments	–	5
Interest receivable	258	370
Total	\$ 425,943	\$ 373,113

These assets (all Level 1) are exchange-traded funds whose fair value is determined from quoted prices on nationally recognized securities exchanges. There are no Level 2 or Level 3 investments.

Investment Strategy

The Retirement Plan's asset allocation and investment strategy are designed to earn returns on plan assets consistent with a reasonable and prudent level of risk. Investments are diversified across classes, sectors, and manager style to minimize the risk of large losses. BHS uses investment managers specializing in each asset category and, where appropriate, provides the investment managers with specific guidelines, which include allowable and/or prohibited investment types. BHS regularly monitors manager performance and compliance with investment guidelines.

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued) (*Dollars in Thousands*)

10. Retirement Plans (continued)

Expected Rate of Return

The expected long-term rate of return on plan assets is based on historical and projected rates of return for current and planned asset categories in the Retirement Plan's investment portfolio. Assumed projected rates of return for each asset category were selected after analyzing historical experience and future expectations of the returns and volatility for assets of that category using benchmark rates. Based on the target asset allocation among the asset categories, the overall expected rate of return for the portfolio was developed and adjusted for historical and expected experience of active portfolio management results compared to benchmark returns and for the effect of expenses paid from plan assets.

11. Malpractice Insurance

The Medical Centers and certain other BHS entities participate in a pooled risk program, whereby BHS entities are the only participants, to insure professional and general liability risks to the extent of certain self-insurance limits. A revocable trust fund has been established for the malpractice self-insured program. The participants' self-insurance retention is \$4,000 per claim with limits of \$50,000 per claim and \$50,000 annual aggregate through a claims-made policy with a third-party insurance carrier. Accrued malpractice losses of \$38,939 and \$24,140 at September 30, 2014 and 2013, respectively, have been discounted at a rate of 2.5% for both years. Losses are accrued when probable and determinable.

In the event that sufficient funds are not available from the trust fund, each participating entity in the program will be assessed its share of the deficiency. If contributions exceed the losses eventually paid, the excess will be applied to reduce the contributions for future periods. Management believes the trust fund is adequately funded to provide for all professional and general liability claims that have occurred through September 30, 2014.

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

12. Leases

Rental expense under various operating leases was \$13,352 and \$13,151 for the years ended September 30, 2014 and 2013, respectively. Future minimum lease payments for noncancelable leases having an initial or remaining lease term in excess of one year are as follows:

	Amount
Year ending September 30	
2015	\$ 8,628
2016	7,801
2017	7,203
2018	6,361
2019	5,506
Thereafter	<u>23,616</u>
	<u><u>\$ 59,115</u></u>

13. Promises to Give

Pledges receivable, included in prepaid expenses and other current assets and other assets in the accompanying consolidated balance sheets, consist of the following:

	September 30		2014	2013
Unconditional promises to give before pledge discounts and allowance for uncollectible pledges	\$ 10,759	\$ 9,095		
Pledge discounts	(317)	(316)		
Allowance for uncollectible pledges	(664)	(1,363)		
Net pledges receivable	<u>\$ 9,778</u>	<u>\$ 7,416</u>		
Amounts due in				
Less than one year	\$ 2,577	\$ 1,702		
One to five years	6,908	5,368		
Over five years	293	346		
Total	<u>\$ 9,778</u>	<u>\$ 7,416</u>		

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued) *(Dollars in Thousands)*

14. Endowments

BHSF operates under the Florida Uniform Management of Institutional Funds Act (FUMIFA) that was effective in May 2004 and was replaced, effective July 1, 2012, by the Florida Uniform Prudent Management of Institutional Funds Act (FUPMIFA).

FUPMIFA enhanced provisions of FUMIFA, applies to all charitable institutions, not just those associated exclusively with education purposes, allows pooling of institutional funds for the purpose of managing and investing, delineates factors to be considered prior to expenditure of funds, provides new procedures for releasing restrictions on small institutional funds, provides for modification of restrictions on the use of endowment funds, and provides for reversion of real property to the board of trustees of the State of Florida Internal Improvement Trust Fund if an entity holding a deed subject to a reverter clause violates the deed restrictions.

In accordance with FUPMIFA, BHSF considers the following in expenditure decisions for its endowment funds

- The purposes of BHSF
- The intent of the donors of the endowment fund
- The terms of the applicable instrument
- The long-term and short-term needs of BHSF in carrying out its purposes
- General economic conditions
- The possible effect of inflation or deflation
- The other resources of BHSF
- Perpetuation of the endowment

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued) (*Dollars in Thousands*)

14. Endowments (continued)

BHSF classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by BHSF in a manner consistent with the standard of prudence prescribed by FUPMIFA.

BHS participates in an endowment matching program with BHSF in which it matches donor contributions to endowments on a tiered basis. Of the net assets transferred, the matching contributions transferred from BHS unrestricted net assets to BHSF restricted net assets for the years ending September 30, 2014 and 2013 are \$6,320 and \$0, respectively.

The investment income and earnings from BHSF's endowment funds are designated for specific purposes. It is the policy of BHSF to expend these funds prudently as expenditures arise that satisfy the purpose restrictions.

BHSF's endowment investment policies are directed by the BHS Investment Committee (Investment Committee) of the Board. BHSF's return objectives include annualized returns over a three to five year period exceeding comparable indices and ranking in the upper tier of a universe of similar funds or managers. BHSF maintains moderate risk posture with respect to both time and risk preference. These risk postures are developed to provide consistent return patterns over a moderate time horizon and are consistent with conserving the purchasing power of BHSF's endowment funds. Strategies employed for achieving BHSF's investment objectives include passively and actively managed funds invested in domestic and international equities, fixed income, and other investments.

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

14. Endowments (continued)

Changes in endowment net assets for the year ended September 30, 2014, consisted of the following

	Donor-Restricted Endowment Funds		
	Temporarily Restricted	Permanently Restricted	Total
Endowment net asset composition, September 30, 2013	\$ 14,094	\$ 23,993	\$ 38,087
Contributions to perpetual endowment	273	8,389	8,662
Net asset transfers from BHS to BHSF	5	6,320	6,325
Reserve adjustments	(1)	(190)	(191)
Investment income	792	2,923	3,715
Transfer of investment income	2,923	(2,923)	—
Expenditures	(924)	—	(924)
Other	9	—	9
Endowment net asset composition, September 30, 2014	<u>\$ 17,171</u>	<u>\$ 38,512</u>	<u>\$ 55,683</u>

Changes in endowment net assets for the year ended September 30, 2013, consisted of the following

	Donor-Restricted Endowment Funds		
	Temporarily Restricted	Permanently Restricted	Total
Endowment net asset composition, September 30, 2012	\$ 11,371	\$ 13,322	\$ 24,693
Contributions to perpetual endowment	—	10,482	10,482
Reserve adjustments	—	15	15
Investment income	847	2,861	3,708
Transfer of investment income	2,861	(2,861)	—
Expenditures	(811)	—	(811)
Transfers	(174)	174	—
Endowment net asset composition, September 30, 2013	<u>\$ 14,094</u>	<u>\$ 23,993</u>	<u>\$ 38,087</u>

Baptist Health System, Inc. and Subsidiaries

Notes to Consolidated Financial Statements (continued)
(Dollars in Thousands)

15. Subsequent Events

BHS has evaluated the impact of subsequent events through January 26, 2015, representing the date on which the financial statements were issued

No subsequent events were identified for recognition in the accompanying consolidated financial statements, other than the amended and restated Hospital Revenue Notes, Series 2009, Series 2010A, and Series 2010C discussed in Note 7, Long Term Debt

Supplementary Information

Baptist Health System, Inc. and Subsidiaries

Consolidating Balance Sheet
(In Thousands)

September 30, 2014

	Southern Baptist Hospital of Florida, Inc.	Baptist Medical Center of the Beaches, Inc.	Baptist Medical Center of Nassau, Inc.	Baptist Health Properties, Inc.	Baptist Health Ambulatory Services, Inc.	Total Obligated Group
Assets						
Current assets						
Cash and cash equivalents	\$ 146,713	17	\$ 16,004	1	\$ 8,263	19
Accounts receivable, net	14,825		1,569		825	
Inventories	17,086		1,938		1,534	
Prepaid expenses and other current assets	22,551		—		107	23
Due from affiliated organizations	11,094		—		454	—
Current portion of assets limited as to use	212,286		19,512		10,623	561
Total current assets						23
Assets limited as to use, less amount required to meet current obligations	1,007,456		48,961		9,649	—
Properties, plant, and equipment, net	663,536		53,100		37,473	66,640
Advances to affiliated organizations	18,919		50,347		51,444	—
Investments	7,518		—		—	—
Interest in net assets of Baptist Health System Foundation, Inc.	54,148		3,230		853	—
Other assets	14,608		24		8	—
Total assets	\$ 1,978,471	\$ 175,174	\$ 110,050	\$ 67,201	\$ 301	\$ 2,331,197

Continued on next page

Baptist Health System, Inc. and Subsidiaries

Consolidating Balance Sheet (continued)
(In Thousands)

September 30, 2014

	Baptist Health System, Inc. (Parent Only)	Pavilion Health Services, Inc.	Baptist Health System Foundation, Inc.	Baptist Medical Center of Clay, Inc. (Development Stage Company)	Baptist Medical Center of Clay, Inc. (Development Stage Company)	Consolidating/ Eliminating Entries	Consolidated Total
Assets							
Current assets							
Cash and cash equivalents	\$ 90,006	\$ 6,258	\$ 25,716	\$ —	\$ —	\$ —	\$ 96,283
Accounts receivable, net	—	4,418	—	—	—	—	196,696
Inventories	—	3,000	2,845	—	—	—	21,637
Prepaid expenses and other current assets	—	—	690	—	—	—	26,533
Due from affiliated organizations	—	—	—	—	(23,695)	—	—
Current portion of assets limited as to use	—	—	—	—	—	11,094	—
Total current assets	90,006	39,392	35,535	—	—	—	352,243
Assets limited as to use, less amount required to meet current obligations	—	—	—	—	—	—	1,066,066
Property, plant, and equipment, net	—	31,574	223	—	—	—	852,787
Advances to affiliated organizations	—	—	1,659	(122,406)	—	—	—
Investments	41,380	—	64,184	(44,380)	—	71,702	—
Interest in net assets of Baptist Health System Foundation, Inc.	—	—	(1,722)	—	(56,509)	—	—
Other assets	4,258	76,242	7,920	—	—	—	103,060
Total assets	\$ 138,644	\$ 147,208	\$ 75,799	\$ —	\$ (246,990)	\$ 2,445,858	

(Continued on next page)

Baptist Health System, Inc. and Subsidiaries

Consolidating Balance Sheet (continued)
(In Thousands)

September 30, 2014

	Southern Baptist Hospital of Florida, Inc.	Baptist Medical Center of the Beaches, Inc.	Baptist Medical Center of Nassau, Inc.	Baptist Health Properties, Inc.	Baptist Health Ambulatory Services, Inc.	Total Obligated Group
Liabilities and net assets						
Current liabilities						
Current portion of long-term debt	\$ 21,822	\$ 1,219	\$ 452	\$ 996	\$ -	\$ 23,493
Accounts payable and accrued liabilities	116,305	6,105	2,752	-	101	126,259
Due to affiliated organizations	-	4,984	2,696	-	95	7,775
Estimated third-party settlements	3,142	534	498	-	-	4,174
Total current liabilities	141,269	12,842	6,398	996	196	161,701
Long-term debt, net of current portion						
Advances from affiliated organizations	494,775	11,939	3,827	-	-	510,541
Other liabilities	-	-	-	49,408	-	49,408
Total liabilities	138,245	1,393	426	-	-	140,064
Net assets						
Unrestricted	1,151,128	1,46,373	98,571	16,797	104	1,412,973
Temporarily restricted	19,837	1,706	339	-	1	21,883
Permanently restricted	33,217	921	489	-	-	34,627
Total net assets	1,204,182	149,000	99,399	16,797	105	1,469,483
Total liabilities and net assets	\$ 1,978,471	\$ 175,174	\$ 110,050	\$ 67,201	\$ 301	\$ 2,331,197

(Continued on next page)

Baptist Health System, Inc. and Subsidiaries

Consolidating Balance Sheet (continued)
(In Thousands)

September 30, 2014

	Baptist Health System, Inc. (Parent Only)	Pavilion Health Services, Inc.	Baptist Health System Foundation, Inc.	Baptist Medical Center of Clay, Inc. (Development Stage Company)	Baptist Medical Center of Clay, Inc. (Development Stage Company)	Consolidating/ Eliminating Entries	Consolidated Total
Liabilities and net assets							
Current liabilities							
Current portion of long-term debt	\$ 4,534	—	\$ 28,318	—	\$ 123	—	\$ 23,493
Accounts payable and accrued liabilities	5,510	10,410	—	—	—	(23,695)	159,234
Due to affiliated organizations	—	—	—	—	—	—	—
Estimated third-party settlements	—	—	—	—	—	—	4,174
Total current liabilities	10,044	38,728	123	—	—	(23,695)	186,901
Long-term debt, net of current portion	—	—	—	—	—	—	510,541
Advances from affiliated organizations	65,032	7,966	—	—	—	(122,406)	—
Other liabilities	12	55,663	364	—	—	—	196,103
Total liabilities	75,088	102,357	487	—	—	(146,101)	893,545
Net assets							
Unrestricted	63,556	44,851	5,970	—	—	(44,380)	1,482,970
Temporarily restricted	—	—	30,830	—	—	(21,882)	30,831
Permanently restricted	—	—	38,512	—	—	(34,627)	38,512
Total net assets	63,556	44,851	75,312	—	—	(100,889)	1,552,313
Total liabilities and net assets	\$ 138,644	\$ 147,208	\$ 75,799	\$ —	\$ —	\$ (246,990)	\$ 2,445,858

Baptist Health System, Inc. and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets
(In Thousands)

Year Ended September 30, 2014

	Southern Baptist Hospital of Florida, Inc.	Baptist Medical Center of the Beaches, Inc.	Baptist Center of Nassau, Inc.	Baptist Health Properties, Inc.	Baptist Health Ambulatory Services, Inc.	Obligated Group	Total Obligated Group
Unrestricted revenues and other support							
Patient service revenues	\$ 945,336	\$ 128,738	\$ 67,199	\$ —	\$ —	\$ (31)	\$ 1,141,242
Provision for bad debts	(51,375)	(12,474)	(2,345)	—	—	—	(66,194)
Net patient service revenues less provision for bad debts	893,961	116,264	64,854	—	—	(31)	1,075,048
Other revenues	17,073	2,104	1,666	5,600	431	(3,013)	23,861
Net assets released from restrictions used for operations	1,925	22	1	—	456	—	2,404
Total unrestricted revenues and other support	912,959	118,390	66,521	5,600	887	(3,044)	1,101,313
Operating expenses							
Salaries and benefits	390,832	47,444	24,146	—	813	11,225	474,460
Professional fees	46,468	3,998	1,993	30	113	1,255	53,857
Supplies	174,880	19,355	7,214	9	4	260	201,722
Interest	8,270	192	45	—	—	—	8,507
Depreciation and amortization	63,079	7,153	3,104	938	10	1,458	75,742
Other expenses	123,950	27,003	13,887	3,552	48	(17,242)	151,198
Total operating expenses	807,479	105,145	50,389	4,529	988	(3,044)	965,486
Income (loss) from operations	105,480	13,245	16,132	1,071	(101)	—	135,827
Nonoperating gains (losses)							
Investment income	73,264	4,071	802	—	—	—	78,137
Equity in losses of subsidiaries	—	—	—	—	—	—	—
Other, net	2,654	377	89	—	—	—	3,120
Total nonoperating gains (losses), net	75,918	4,448	891	—	—	—	81,257
Excess (deficiency) of revenues and gains over expenses and losses	181,398	17,693	17,023	1,071	(101)	—	217,084

Continued on next page

Baptist Health System, Inc. and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets (continued)
(In Thousands)

Year Ended September 30, 2014

	Baptist Health System, Inc (Parent Only)	Pavilion Health Services, Inc	Baptist Health System Foundation, Inc	Baptist Medical Center of Clay, Inc (Development Stage Company)	Consolidating/ Eliminating Entries	Consolidated Total
Unrestricted revenues and other support						
Patient service revenues	\$ -	\$ 224,889	\$ -	\$ -	\$ -	\$ 1,366,092
Provision for bad debts		(11,773)				(77,967)
Net patient service revenues less provision for bad debts		213,116				1,288,125
Other revenues		61,188	117			57,731
Net assets released from restrictions used for operations			\$ 8885			
Total unrestricted revenues and other support		274,304	6,012			4,098
Operating expenses						
Salaries and benefits	72	208,190	1,726			(48)
Professional fees	546	1,336	293			(16,652)
Supplies	11	44,387	151			(1,034)
Interest	-	50	-			-
Depreciation and amortization		8,896	11			84,649
Other expenses	5,447	33,535	6,741			(13,931)
Total operating expenses	60,076	296,394	8,922			182,990
Income (loss) from operations	(60,076)	(22,090)	(2,920)			(14,741)
Nonoperating gains (losses)						
Investment income	342	-	1,531			80,010
Equity in losses of subsidiaries	(22,814)	(28)	-			(28)
Other net	4,266	(670)	-			6,716
Total nonoperating gains (losses) net	(18,196)	(698)	1,531			86,698
Excess (deficiency) of revenues and gains over expenses and losses	(24,272)	(22,788)	(1,389)			191,439

Continued on next page

Baptist Health System, Inc and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets (continued)
(In Thousands)

Year Ended September 30, 2014

	Southern Baptist Hospital, Inc.	Baptist Medical Center of the Beaches, Inc.	Baptist Medical Center of Nassau, Inc.	Baptist Health Properties, Inc.	Baptist Health Ambulatory Services, Inc.	Obligated Group	Total Obligated Group
Unrestricted net assets	\$ 181,398	\$ 17,693	\$ 17,023	\$ 1,071	\$ (101)	\$ (101)	\$ 217,084
Excess (deficiency) of revenues and gains over expenses and losses							
Other changes in unrestricted net assets							
Changes related to pension and executive compensation other than period costs	(45,905)						(45,905)
Transfers from to affiliated organizations	(19,229)	(4,229)	(5,517)	(214)			(29,229)
Transfers to temporarily restricted net assets							
Contributions for the purchase of property, plant and equipment							
Contributions from to BHSF							
Net assets released from restrictions used for purchase of property, plant and equipment	1,333	1,208	2				2,013
Unrealized gain on interest rate swap agreements	(70)	(4)					(74)
Other including net asset transfers from BHS to BHSF for endowment matching program	(157)	(109)	15	1			(250)
	117,421	14,530	11,563	858	(101)		144,303
Temporarily restricted net assets							
Restricted contributions	3,908	1,060	151				5,530
Investment gains	408	14	8				428
Transfer from temporarily restricted net assets							
Transfer of investment gains from permanently restricted net assets							
Net assets released from restrictions	2,517	24	10				2,557
Net asset transfers from BHS to BHSF	(3,013)	(1,229)	(3)				(4,70)
	1	2	2				
	3,819	(120)	104				3,760
Permanently restricted net assets							
Contributions	7,026	95	297				7,118
Investment gains	2,517	24	10				2,557
Transfer of investment gains to temporarily restricted net assets	(2,517)	(24)	(10)				(2,557)
Transfer of BHSF investment gains to temporarily restricted fund							
Net asset transfers from BHS to BHSF for endowment matching program							
	5,149	760	60				6,014
	12,175	861	300				13,333
Increase (decrease) in permanently restricted net assets							
Net assets beginning of year	133,418	15,300	12,003	858	(1,481)		161,491
Net assets end of year	1,070,764	133,700	8,330	15,930	2,53		1,307,002
	\$ 1,204,182	\$ 149,000	\$ 30,300	\$ 16,750	\$ 105		\$ 1,469,483

Continued on next page

Baptist Health System, Inc and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets (continued)
(In Thousands)

Year Ended September 30, 2014

	Baptist Health System, Inc (Parent Only)	Pavilion Health Services, Inc	Baptist Health System Foundation, Inc	Baptist Medical Center of Clay, Inc (Development Stage Company)	Consolidating/ Eliminating Entries	Consolidated Total
Unrestricted net assets						
Excess (deficiency) of revenues and gains over expenses and losses	\$ (24,272)	\$ (22,788)	\$ (1,389)	\$ (1,389)	\$ 22,804	\$ 191,439
Other changes in unrestricted net assets	—	—	—	—	—	(45,905)
Changes related to pension and executive compensation other than period costs	29,000	23,103	—	—	(22,881)	—
Transfers from (to) affiliated organizations	—	—	(9)	—	—	(9)
Transfers to temporarily restricted net assets	—	—	—	—	—	—
Contributions for the purchase of property, plant and equipment	—	—	2,921	—	—	54
Contributions from (to) BHSF	(2,921)	—	—	—	—	—
Net assets released from restrictions used for purchase of property, plant and equipment	—	—	—	—	—	—
Unrealized gain on interest-rate swap agreements	—	—	—	—	—	—
Other including net asset transfers from BHS to BHSF for endowment matching program	(6,199)	(297)	—	—	(231)	(7,280)
Increase (decrease) in unrestricted net assets	(4,692)	18	1,523	—	(314)	140,838
Temporarily restricted net assets						
Temporarily restricted net assets	—	—	6714	—	(4,928)	7,322
Restricted contributions	—	—	792	—	(428)	792
Investment gains	—	—	9	—	—	9
Transfer from temporarily restricted net assets	—	—	2,223	—	(2,557)	2,923
Transfer of investment gains from permanently restricted net assets	—	—	(5,885)	—	3,944	(6,711)
Net assets released from restrictions	—	—	5	—	(5)	5
Net asset transfers from BHS to BHSF	—	—	4,558	—	(3,974)	4,340
Increase (decrease) in temporarily restricted net assets	—	—	—	—	—	—
Permanently restricted net assets						
Permanently restricted net assets	—	—	8,199	—	(7,418)	8,199
Contributions	—	—	2,923	—	(2,557)	2,923
Investment gain	—	—	—	—	2,557	—
Transfer of investment gains to temporarily restricted net assets	—	—	(2,923)	—	—	(2,923)
Transfer of BHSF investment gains to temporarily restricted fund	—	—	6,320	—	(6,014)	6,320
Net asset transfers from BHS to BHSF for endowment matching program	—	—	14,519	—	(13,432)	14,519
Increase (decrease) in permanently restricted net assets	—	—	—	—	—	—
Increase (decrease) in net assets	(4,692)	18	20,600	—	(17,720)	159,697
Net assets, beginning of year	68,248	41,833	54,712	—	(83,169)	1,392,616
Net assets, end of year	\$ 63,556	\$ 41,851	\$ 75,312	\$ —	\$ (100,889)	\$ 1,552,313

Baptist Health System, Inc. and Subsidiaries

Consolidating Balance Sheet
(In Thousands)

September 30, 2013

	Southern Baptist Hospital of Florida, Inc.	Baptist Medical Center of the Beaches, Inc.	Baptist Medical Center of Nassau, Inc.	Baptist Health Properties, Inc.	Baptist Health Ambulatory Services, Inc.	Total Obligated Group
Assets						
Current assets						
Cash and cash equivalents	\$ 25	\$ 1	\$ 1	\$ 1	\$ 1	\$ 27
Accounts receivable, net	114,970	13,612	6,988	—	—	135,570
Inventories	12,941	1,509	737	—	—	15,187
Prepaid expenses and other current assets	13,861	874	457	190	23	15,405
Due from affiliated organizations	16,206	—	—	199	—	16,405
Current portion of assets limited as to use	9,215	—	—	—	—	9,215
Total current assets	167,218	15,996	8,183	389	23	191,899
Assets limited as to use, less amounts required to meet current obligations						
Property, plant, and equipment, net	856,122	44,889	8,846	—	—	909,857
Advances to affiliated organizations	660,998	56,742	37,504	65,925	3	821,172
Investments	49,202	38,728	42,394	—	322	130,646
Interest in net assets of Baptist Health System Foundation, Inc	7,468	—	—	—	—	7,468
Other assets	38,736	1,899	385	—	—	41,020
Total assets	15,661	73	297	—	—	16,031
	\$ 1,795,405	\$ 158,327	\$ 97,609	\$ 66,314	\$ 3,48	\$ 2,118,003

Continued on next page

Baptist Health System, Inc. and Subsidiaries

Consolidating Balance Sheet (continued)
(In Thousands)

September 30, 2013

	Baptist Health System, Inc. (Parent Only)	Pavilion Health Services, Inc.	Baptist Health System Foundation, Inc.	Baptist Medical Center of Clay, Inc. (Development Stage Company)	Consolidating/ Eliminating Entries	Consolidated Total
Assets						
Current assets						
Cash and cash equivalents	\$ 97,338	\$ 6,111	-\$	-\$	-\$	\$ 103,476
Accounts receivable, net	-	23,961	-	-	-	159,531
Inventories	-	4,091	-	-	-	19,278
Prepaid expenses and other current assets	-	3,299	1,710	-	-	20,414
Due from affiliated organizations	-	-	-	-	(16,405)	-
Current portion of assets limited as to use	-	-	-	-	-	9,215
Total current assets	97,338	37,462	1,710	-	(16,405)	311,914
Assets limited as to use, less amounts required to meet current obligations	-	-	-	-	-	909,857
Property, plant, and equipment, net	32,113	68	-	-	-	853,353
Advances to affiliated organizations	-	-	-	-	(130,646)	-
Investments	41,066	-	51,933	-	(44,066)	59,401
Interest in net assets of Baptist Health System Foundation, Inc.	-	-	(1,917)	-	(39,103)	-
Other assets	1,353	64,027	6,078	-	-	87,489
Total assets	\$ 142,757	\$ 133,602	\$ 57,872	\$ -	\$ (230,220)	\$ 2,222,011

Continued on next page

Baptist Health System, Inc. and Subsidiaries

Consolidating Balance Sheet (continued)
(In Thousands)

September 30, 2013

	Southern Baptist Hospital of Florida, Inc.	Baptist Medical Center of the Beaches, Inc.	Baptist Medical Center of Nassau, Inc.	Baptist Health Properties, Inc.	Baptist Health Ambulatory Services, Inc.	Total Obligated Group
Liabilities and net assets						
Current liabilities						
Current portion of long-term debt	\$ 22,144	\$ 1,185	\$ 422	\$ —	\$ —	\$ 23,751
Accounts payable and accrued liabilities	84,693	4,934	2,046	563	55	92,291
Due to affiliated organizations	—	2,969	2,168	—	40	5,177
Estimated third-party settlements	4,112	783	844	—	—	5,739
Total current liabilities	<u>110,949</u>	<u>9,871</u>	<u>5,480</u>	<u>563</u>	<u>95</u>	<u>126,958</u>
Long-term debt, net of current portion						
Advances from affiliated organizations	516,676	13,147	4,293	—	—	534,116
Other liabilities	—	—	—	49,812	—	49,812
Total liabilities	<u>97,016</u>	<u>1,609</u>	<u>500</u>	<u>49,812</u>	<u>—</u>	<u>99,125</u>
Net assets						
Unrestricted	1,033,704	131,814	87,008	15,939	205	1,268,670
Temporarily restricted	16,018	1,826	235	—	48	18,127
Permanently restricted	21,042	60	93	—	—	21,195
Total net assets	<u>1,070,764</u>	<u>133,700</u>	<u>87,336</u>	<u>15,939</u>	<u>253</u>	<u>1,307,992</u>
Total liabilities and net assets	<u>\$ 1,795,405</u>	<u>\$ 158,327</u>	<u>\$ 97,609</u>	<u>\$ 66,314</u>	<u>\$ 3,48</u>	<u>\$ 2,118,003</u>

Continued on next page

Baptist Health System, Inc. and Subsidiaries

Consolidating Balance Sheet (continued)
(In Thousands)

September 30, 2013

	Baptist Health System, Inc. (Parent Only)	Pavilion Health Services, Inc.	Baptist Health System Foundation, Inc.	Baptist Medical Center of Clay, Inc. (Development Stage Company)	Consolidating/ Eliminating Entries	Consolidated Total
Liabilities and net assets						
Current liabilities						
Current portion of long-term debt	\$ 1,253	—	—	—	—	\$ 23,751
Accounts payable and accrued liabilities	—	31,102	174	—	—	123,567
Due to affiliated organizations	1,253	8,915	1,060	—	(16,405)	—
Estimated third-party settlements	—	—	—	—	—	5,739
Total current liabilities	1,253	40,017	1,234	—	(16,405)	153,057
Long-term debt, net of current portion						
Advances from affiliated organizations	72,968	6,226	1,640	—	—	534,116
Other liabilities	288	42,526	286	—	(130,646)	—
Total liabilities	73,256	48,752	1,926	—	(130,646)	676,341
Net assets						
Unrestricted	68,248	44,833	4,447	—	(44,066)	1,342,132
Temporarily restricted	—	—	26,272	—	(17,908)	26,491
Permanently restricted	—	—	23,993	—	(21,195)	23,993
Total net assets	68,248	44,833	54,712	—	(83,169)	1,392,616
Total liabilities and net assets	\$ 142,757	\$ 133,602	\$ 57,872	\$ —	\$ (230,220)	\$ 2,222,011

Baptist Health System, Inc. and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets
(In Thousands)

Year Ended September 30, 2013

	Southern Baptist Hospital of Florida, Inc.	Baptist Medical Center of the Beaches, Inc.	Baptist Nassau, Inc.	Baptist Health Properties, Inc.	Baptist Health Ambulatory Services, Inc.	Obligated Group	Eliminations	Total Obligated Group
Unrestricted revenues and other support								
Patient service revenues	\$ 895,014 (84,422)	\$ 129,968 (20,622)	\$ 70,673 (9,248)	\$ —	\$ —	\$ (31)	\$ 1,095,624 (114,292)	
Provision for bad debts	810,592	109,346	61,425	—	—	—	—	881,332
Net patient service revenues less provision for bad debts	17,481	2,779	2,065	4,343	425	(31)	(2,848)	24,245
Other revenues	1,607	8	—	—	478	—	—	2,093
Net assets released from restrictions used for operations	829,680	112,133	63,490	4,343	903	(2,879)	—	1,007,670
Total unrestricted revenues and other support								
Operating expenses								
Salaries and benefits	376,475	48,696	24,285	—	730	9,092	459,278	
Professional fees	37,641	4,255	2,473	28	64	901	45,362	
Supplies	163,222	17,380	6,777	11	2	270	187,662	
Interest	8,679	212	47	—	—	—	8,938	
Depreciation and amortization	57,597	6,886	3,292	1,157	6	1,089	70,127	
Other expenses	107,073	22,790	11,606	2,962	60	(14,231)	130,260	
Total operating expenses	750,687	100,219	38,480	4,158	862	(2,879)	901,527	
Income (loss) from operations	78,993	11,914	15,010	185	41	—	—	106,143
Nonoperating gains (losses)								
Investment income	67,951	4169	810	—	—	—	—	72,870
Equity in losses of subsidiaries	—	—	—	—	—	—	—	—
Other net	8,138	747	195	1	—	—	—	9,081
Total nonoperating gains (losses) net	76,089	4,856	1,005	1	—	—	—	81,951
Excess (deficiency) of revenues and gains over expenses and losses	155,082	16,770	16,015	186	41	—	—	188,094

Continued on next page

Baptist Health System, Inc. and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets (continued)
(In Thousands)

Year Ended September 30, 2013

	Baptist Health System, Inc. (Parent Only)	Pavilion Health Services, Inc.	Baptist Health System Foundation, Inc.	Baptist Medical Center of Clay, Inc. (Development Stage Company)	Consolidating/ Eliminating Entries	Consolidated Total
\$	\$	\$	\$	\$	\$	\$
Unrestricted revenues and other support						
Patient service revenues	—	212,069	—	—	(39)	1,307,654
Provision for bad debts	—	(10,176)	—	—	—	(124,468)
Net patient service revenues less provision for bad debts	—	201,893	—	—	(39)	1,183,186
Other revenues	—	57,418	122	—	(24,657)	57,128
Net assets released from restrictions used for operations	—	—	8,463	—	(6,808)	3,748
Total unrestricted revenues and other support	—	259,311	8,585	—	(31,504)	1,244,062
Operating expenses						
Salaries and benefits	—	199,386	1,034	—	1,293	660,991
Professional fees	—	2,140	238	—	(14,457)	33,283
Supplies	—	39,809	38	—	(808)	226,701
Interest	—	88	—	—	—	9,026
Depreciation and amortization	—	7,579	11	—	157	77,774
Other expenses	593	32,436	9,368	—	(17,689)	154,968
Total operating expenses	593	281,438	10,689	—	(31,504)	1,162,743
Income (loss) from operations	(593)	(22,127)	(2,104)	—	—	81,319
Nonoperating gains (losses)						
Investment income	360	19	1,580	—	—	74,829
Equity in losses of subsidiaries	(22,017)	(134)	—	—	22,017	(134)
Other, net	(240)	228	—	—	—	9,069
Total nonoperating gains (losses), net	(21,897)	113	1,580	—	22,017	83,764
Excess (deficiency) of revenues and gains over expenses and losses	(22,490)	(22,014)	(524)	—	22,017	165,083

Continued on next page

Baptist Health System, Inc. and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets (continued)
(In Thousands)

Year Ended September 30, 2013

	Southern Baptist Hospital of Florida, Inc.	Baptist Medical Center of the Beaches, Inc.	Baptist Center of Nassau, Inc.	Baptist Properties, Inc.	Baptist Health Services, Inc.	Baptist Health Ambulatory Services, Inc.	Obligated Group Eliminations	Total Obligated Group
Unrestricted net assets	\$ 155,082	\$ 10,770	\$ 10,015	\$ 186	\$ 41	\$ 41	-\$ 188,044	
Excess (deficiency) of revenues and gains over expenses and losses	55,020	-(2,211)	-(11,477)	(341)	-	-		55,020
Other change in unrestricted net assets	(40,390)	-	100	-	-	-		(41,091)
Changes related to pension and executive compensation	-	-	-	-	-	-		-
Other than pension costs	-	-	-	-	-	-		-
Transfers to from affiliated organizations	58	-	-	-	-	-		58
Contributions for the purchase of property, plant and equipment	-	-	-	-	-	-		-
Net assets released from restrictions used for purchase of property, plant and equipment	4,237	1,048	1,49	-	-	-		5,134
Unrealized gain on interest rate swap agreement	1,532	95	-	-	-	-		1,627
Other	(308)	1	-	(1)	(1)	(1)		(302)
	215,840	8,703	4,794	1,180	40	40		220,221
Temporarily restricted net assets								
Restricted contributions	4,734	644	123	-	-	-		5,087
Investment gains	4,40	15	8	-	-	-		4,63
Transfer of investment gains from permanently restricted net assets	2,460	4	13	-	-	-		2,477
Net assets released from restrictions	(5,363)	(1,054)	(1,51)	-	(47)	(47)		(5,415)
Other	-	-	-	-	-	-		-
Increase (decrease) in temporarily restricted net assets	2,271	(301)	(7)	-	0	0		1,882
Permanently restricted net assets								
Contributions	10,204	33	1	-	-	-		10,208
Investment gains	2,460	4	13	-	-	-		2,477
Transfer of investment gains to temporarily restricted net assets	-	-	-	-	-	-		-
Other	(2,460)	(4)	(13)	-	-	-		(2,477)
Increase in permanently restricted net assets	10,204	33	1	-	-	-		10,208
Increase (decrease) in net assets	228,375	8,345	4,788	(150)	40	40		241,401
Net assets, beginning of year	812,380	125,355	82,548	10,005	204	204		1,060,501
Net assets, end of year	\$ 1,070,041	\$ 133,700	\$ 87,330	\$ 15,920	\$ 253	\$ 253		\$ 1,303,902

Continued on next page

Baptist Health System, Inc. and Subsidiaries

Consolidating Statement of Operations and Changes in Net Assets (continued)
(In Thousands)

Year Ended September 30, 2013

	Baptist Health System, Inc. (Parent Only)	Pavilion Health Services, Inc.	Baptist Health System Foundation, Inc.	Baptist Medical Center of Clay, Inc. (Development Stage Company)	Consolidating/ Eliminating Entries	Consolidated Total
Unrestricted net assets						
Excess (deficiency) of revenues and gains over expenses and losses	\$ (22,190)	\$ (22,014)	\$ (524)	\$ -	\$ 22,017	\$ 105,083
Other changes in unrestricted net assets						
Changes related to pension and executive compensation other than period costs						
Transfers (to) from affiliated organizations	\$ 18,805	18,221	2,105	(1,000)	(18,502)	3,020
Contributions for the purchase of property, plant and equipment	-	-	-	-	-	-
Net assets released from restrictions used for purchase of property, plant and equipment	-	-	-	-	-	5,134
Unrealized gain on interest rate swap agreements	-	-	-	-	-	102
Other	153	(301)	(1)	(120)		(571)
	3,858	(3,394)	1,580	(1,000)	3,025	26,360
Increase (decrease) in unrestricted net assets						
Temporarily restricted net assets						
Restricted contributions	-	-	6,504	-	(5,501)	6,000
Investment gains	-	-	847	-	(4,033)	847
Transfer of investment gains from permanently restricted net assets	-	-	2,801	-	(2,477)	2,801
Net assets released from restrictions	-	-	(8,402)	-	6,325	(3,822)
Other	-	-	-	-	(4)	(4)
	-	-	1,750	-	(2,120)	1,912
Permanently restricted net assets						
Contributions	-	-	10,671	-	(10,298)	10,671
Investment gains	-	-	2,861	-	(2,477)	2,861
Transfer of investment gains to temporarily restricted net assets	-	-	(2,801)	-	-	(2,801)
Other	-	-	-	-	2,477	-
Increase in permanently restricted net assets	-	-	10,671	-	(10,298)	10,671
Increase (decrease) in net assets						
Net assets beginning of year	\$ 30,390	\$ (3,394)	\$ 14,001	\$ (1,000)	\$ (9,323)	\$ 2,943
Net assets end of year	\$ 68,218	\$ (4,822)	\$ 10,711	\$ 1,000	\$ (3,846)	\$ 11,130
	<u>\$ 68,218</u>	<u>\$ 4,833</u>	<u>\$ 14,712</u>	<u>\$ -</u>	<u>\$ (3,846)</u>	<u>\$ 1302,016</u>

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